

DISTRICT OF COLUMBIA OFFICE OF ADMINISTRATIVE HEARINGS
NOTICE OF FINAL RULEMAKING

The Chief Administrative Law Judge of the Office of Administrative Hearings, pursuant to the authority set forth in Section 8 of the Office of Administrative Hearings Establishment Act of 2001, effective March 6, 2002 (D.C. Law 14-76, D.C. Official Code § 2-1831.05(b)(7)), gives notice of the adoption of the following amendments to Chapter 28 of Title 1 of the District of Columbia Municipal Regulations (DCMR). These rules prescribe the rules of trial practice and procedure in matters before OAH.

These rules were first published in the *D.C. Register* on February 4, 2005 at 52 DCR 996 and on April 15, 2005, at 52 DCR 3838. Based upon the comments received, there are no substantive changes to the published rules. Sections 2839.14, 2840.20 and 2840.21 have been given different section numbers in Chapter 28, but the text of the rules have not been changed since they were proposed on February 4, 2005. These rules will be effective upon the publication of this notice of final rulemaking in the *D.C. Register*.

Sections 2804.4 and 2804.5 of 1 DCMR Chapter 28 are amended to read as follows:

- 2804.4 In any case in which the Government represents that a Notice of Violation was served by certified mail, it shall file a copy of the certified mail return receipt (U.S.P.S. Form 3811, or its successor) signed by the recipient, or an affidavit or declaration sufficient to demonstrate that the Notice of Violation was received by the Respondent, or if not received, the reason, to the best of the Government's knowledge, why it was not received. Any submission made under this Section shall also include a photocopy of any envelope returned to the Government by the United States Postal Service as undelivered or undeliverable, and any paper or document appended to such envelope by the United States Postal Service.
- 2804.5 Unless the Respondent has answered the Notice of Violation or otherwise appeared, any case in which the Government has failed to comply with Section 2804.4 within forty-five (45) calendar days of the filing of the Notice of Violation shall be dismissed without prejudice for lack of sufficient proof of proper service. If a case is pending at the time Section 2804.4 is adopted, such compliance shall occur within forty-five (45) calendar days of the filing of the Notice of Violation, or fourteen (14) calendar days of the adoption of Section 2804.4, whichever is later.

Sections 2805.6, 2805.9, 2805.10 and 2805.11 of 1 DCMR Chapter 28 are added as follows:

- 2805.6 Reserved.

- 2805.9 In addition to filing a written hearing request or making an oral hearing request to the Department of Human Services, an individual seeking a hearing in any case involving Medicaid, Food Stamps, Temporary Assistance for Needy Families ("TANF"), Emergency Shelter, Interim Disability Assistance, General Assistance for Children, Program on Work, Employment and Responsibility ("POWER"), Energy Assistance, Rehabilitation Services, Burial Assistance benefits or any other benefits provided by the Department of Human Services, may make an oral hearing request, in person or by telephone, to a docket clerk of the Office of Administrative Hearings during regular business hours. This subsection shall be effective on May 1, 2005.
- 2805.10 Any oral hearing request authorized by Section 2805.9 must specify the type of benefits at issue and must describe the action or actions taken by an agency of the District of Columbia to which the person objects.
- 2805.11 Upon receipt of an oral hearing request authorized by Section 2805.9, the docket clerk shall promptly transmit a written summary of the request to the agency whose decision is being challenged.

Section 2808.1 of 1 DCMR Chapter 28 is amended to read as follows:

- 2808.1 Except as otherwise provided in these Rules, by statute, or by order of this administrative court, every order required by its terms to be served, every pleading, except an answer to a Notice of Infraction or Notice of Violation, and every other paper filed in this administrative court shall be served upon the parties, or, if represented, their attorneys or authorized representatives. Proof of service must be filed in accordance with Rule 2810.

Section 2810.4 of 1 DCMR Chapter 28 is amended to read as follows:

- 2810.4 Except for an answer and plea to a Notice of Infraction or Notice of Violation, or as otherwise provided by statute or these Rules, or as otherwise ordered by this administrative court, all papers filed with this administrative court must contain a certificate of service identifying the individual serving the document as well as the parties served, the manner of service and date of service. A failure to provide a certificate of service according to this Rule may result in a paper being rejected for filing by the Clerk or ordered stricken by the presiding Administrative Law Judge.

Section 2818.4 of 1 DCMR Chapter 28 is added as follows:

- 2818.4 In any case in which a request for hearing is filed appealing any decision by a private party claiming authority to make that decision on behalf of a government official, the private party shall not be permitted to appear before this administrative court until it files a delegation signed by an authorized government official granting such authority, or a submission demonstrating a general delegation of such governmental authority to the private party consistent with the

requirements of constitutional due process. In the event no appearance is entered by the Government, or by a private party consistent with this Section, the presiding Administrative Law Judge may enter an order of default using the procedures applicable to Section 2818.3 of this Rule.

Sections 2820.1 and 2820.2 of 1 DCMR Chapter 28 are amended to read as follows:

- 2820.1 Evidence shall not be excluded on the ground that it is hearsay. To the extent it promotes fairness, equity and substantial justice for all parties, the admissibility of relevant, non-cumulative evidence is favored.
- 2820.2 In determining the weight of evidence, the Federal Rules of Evidence shall not be binding, but may be deemed persuasive authority. In determining the weight to be given hearsay evidence, the presiding Administrative Law Judge may consider whether a recognized hearsay exception is applicable.

Section 2822.1 of 1 DCMR Chapter 28 is amended as follows:

- 2822.1 Subpoenas shall only be issued by the presiding Administrative Law Judge either on his or her own motion or on the motion of a party, and shall be served by the party requesting the subpoena or as otherwise ordered by this administrative court in accordance with the provisions of D.C. Superior Court Civil Rule 45.

Sections 2830.1, 2830.2, 2830.3 and 2830.4 of 1 DCMR Chapter 28 are amended to read as follows:

- 2830.1 For cases arising under D.C. Official Code Title 8, Chapter 8 in which a final order has been issued, the Government may elect to move to reopen a case, as of right, to seek a collateral order providing for abatement costs. The Government may do so by filing and serving upon respondent a bill of abatement costs not later than one hundred twenty (120) days after service of the final order, or by July 15, 2005, whichever is later. Failure, without good cause, to file and serve a bill of abatement costs in the time prescribed in this Section shall preclude recovery.
- 2830.2 A request by a respondent for a hearing on the Government's motion for abatement cost recovery shall be in writing, and shall be filed within thirty (30) days of service of the bill of abatement costs by the Government upon the respondent.
- 2830.3 If a respondent files a timely request for a hearing to contest a claim for abatement costs made pursuant to Section 2830.1, the presiding Administrative Law Judge shall hold a hearing limited to the issue of abatement costs. A Respondent previously found liable for a violation may not contest his or her liability for that violation at the hearing.
- 2830.4 If a respondent does not file a request for a hearing within the deadline established in Section 2830.2, the presiding Administrative Law Judge may decide, solely on

the motion and accompanying papers filed by the Government, whether the Government is entitled to an order granting abatement costs and the amount of any such costs. Alternatively, the presiding Administrative Law Judge may order the Government and the respondent to appear for a hearing if he or she cannot determine the issues based on the motion and accompanying papers.

Section 2830.5 of 1 DCMR Chapter 28 is repealed.

Section 2832.3 of 1 DCMR Chapter 28 is amended to read as follows:

2832.3 Unless otherwise ordered by an Administrative Law Judge, the filing of a motion for reconsideration shall not stay the effectiveness of the order. With respect to a final order, if such a motion is timely filed, the order shall not be deemed final for purposes of judicial review until the motion is ruled upon by the Administrative Law Judge or is denied.

Sections 2838.1 and 2838.2 of 1 DCMR Chapter 28 are amended to read as follows:

2838.1 An individual or other party may be represented before this administrative court by an attorney. Unless otherwise provided by statute or these Rules, only attorneys who are active members in good standing of the District of Columbia Bar, or who are authorized to practice law in the District of Columbia pursuant to Rules 49(c) (1), (4), (8) or (9) of the District of Columbia Court of Appeals, may appear before this administrative court as a representative of a party.

2838.2 An attorney who is not a member of the District of Columbia Bar, and who is not authorized to practice law in the District of Columbia pursuant to Rules 49(c) (1), (4), (8) or (9) of the District of Columbia Court of Appeals, may appear before this administrative court, upon the filing and granting of a motion to appear *pro hac vice*, in which the attorney shall declare under penalty of perjury:

- (a) That I have not applied for admission *pro hac vice* in more than five cases in this administrative court or in the courts of the District of Columbia during this calendar year;
- (b) That I am a member in good standing of the bar of the highest court(s) of the State(s) of ____ (list all states);
- (c) That there are no disciplinary complaints pending against me for violation of the rules of the courts of those states;
- (d) That I have not been suspended or disbarred for disciplinary reasons from practice in any court;
- (e) That I do not practice or hold out to practice law in the District of Columbia;

- (f) That I have read all of the rules of this administrative court and have complied fully with District of Columbia Court of Appeals Rule 49. The reason(s) I am applying for admission *pro hac vice* are as follows: _____ (list all reasons); and
- (g) I acknowledge the jurisdiction of this administrative court and the courts of the District of Columbia over my professional conduct, and I agree to be bound by the District of Columbia Court of Appeals Rules of Professional Conduct, in this matter, if I am admitted *pro hac vice*. I have applied for admission *pro hac vice* in this administrative court and in the courts of the District of Columbia _____ (list number) times previously in this calendar year.

Sections 2839.11, 2839.12, 2839.13 and 2839.14 of 1 DCMR Chapter 28 are added as follows:

- 2839.11 As required by Federal law, 42 CFR 431.206(b)(3), in cases involving Medicaid benefits, any applicant for, or recipient of, those benefits may be represented by an attorney, a relative, a friend, or other spokesperson.
- 2839.12 As required by Federal law, 7 CFR 273.15(f), in cases involving Food Stamps benefits, any household that is an applicant for, or recipient of Food Stamps benefits, may be represented by a household member, or a representative, such as an attorney, a relative, a friend or other spokesperson.
- 2839.13 As required by the District of Columbia Public Assistance Act, D.C. Official Code § 4-210.04(a), an individual may be represented by an attorney or by a lay person who is not an employee of the District in cases involving the following public benefit programs: Temporary Assistance for Needy Families ("TANF"); Interim Disability Assistance; General Assistance for Children; Program on Work, Employment and Responsibility ("POWER"); and Emergency Family Shelter Services.
- 2839.14 Any person demonstrating he or she is authorized by the United States Tax Court to represent litigants before that court, may represent a litigant before this administrative court in any action arising under D.C. Official Code § 2-1831.03(b)(4), and upon the same basis as would be permitted by the United States Tax Court. Such practice is also subject to regulation under Sections 2838.5, 2838.6, and 2838.7 of these Rules.

Section 2840.2 of 1 DCMR Chapter 28 is amended as follows:

- 2840.2 Where a decision of an Administrative Law Judge is in conflict with a decision of a least one other Administrative Law Judge on the same issue, or where litigants before this administrative court would likely benefit from a clear precedent on a particular legal issue, the Chief Administrative Law Judge may, upon motion by a

party in a pending adjudicative case, or upon his or her own motion and in the interest of justice, assign three Administrative Law Judges to sit on a panel and decide all or part of the pending case. To the extent administratively convenient and operationally practical, the Chief Administrative Law Judge shall seek to appoint Administrative Law Judges who have not participated in prior conflicting decisions, but may elect to appoint the Administrative Law Judge who has presided over the pending adjudicative case. Any order or interlocutory order issued by such a panel shall be treated as a binding precedent of a higher court in all matters subsequently coming before this administrative court, unless later reversed or modified by law, by decision of the District of Columbia Court of Appeals, or by a subsequent order of that panel or another panel acting under this Section. In determining whether to convene a panel under this Section, the Chief Administrative Law Judge may consider, among other things, whether the panel is likely to provide clarity and guidance in an important legal issue before this administrative court.

- (a) Except as otherwise ordered, a motion brought under this Section shall be deemed denied unless granted within ten (10) days of its filing. The denial of a request for a panel under this Section shall be deemed an interlocutory order. A motion under this Section may not be filed within thirty (30) days prior to a trial date, except by leave of the presiding Administrative Law Judge. Unless granted by the Chief Administrative Law Judge, the mere filing of a motion under this Section shall have no effect on a pending case.
- (b) Where a case has been commenced before this administrative court, and upon it appearing to be a non-frivolous question about whether this administrative court possesses legal authority to hear and decide the case, the presiding Administrative Law Judge shall promptly inform the Chief Administrative Law Judge or his or her designee of this, and no final order shall be issued in that case until at least seven (7) calendar days after such notice is provided. Nothing in this Subsection precludes the issuance of an interlocutory order granting interim relief.
- (c) Any order or interlocutory order with the effect of invalidating these Rules or construing them to be otherwise inoperative, whether in whole or in part, may only be issued under the authority of this Section. Any order or interlocutory order issued under this Section shall be entitled "Order Pursuant to Rule 2840" or "Final Order Pursuant to Rule 2840" as appropriate.

Sections 2840.20 and 2840.21 of 1 DCMR Chapter 28 are added as follows:

- 2840.20 The term "Caseload" for purposes of Section 16(e) of the Act shall be measured and reported based on any projected increases or decreases in the number of individual cases commenced by a government agency under 1 DCMR §§ 2803, 2804 or 2805. A government agency commencing cases under 1 DCMR 2803

may, in the alternative, elect to report projected increases or decreases in the number of individual infractions charged. This Section codifies existing practice and shall be effective October 1, 2004, *nunc pro tunc*.

- 2840.21 The Chief Administrative Law Judge or his or her designee may administer oaths of office to an Administrative Law Judge or other employee of this administrative court.

Sections 2843.1, 2843.2, 2843.3 and 2843.4 of 1 DCMR Chapter 28 is added to read as follows:

2843 Decision Deadlines in Public Benefits Cases

- 2843.1 As required by Federal law, 7 CFR 273.15(c), decisions in cases involving Food Stamps benefits shall be issued and served upon the parties within 60 days of receipt of the hearing request.
- 2843.2 Reserved.
- 2843.3 Reserved.
- 2843.4 In all cases described in subsections 1 through 3, if a postponement of the hearing date is granted to the Petitioner, the deadline for the issuance and service of the decision shall be extended for as many days as the hearing is postponed.

The definition of "Filed" in Section 2899 of 1 DCMR Chapter 28 is amended as follows:

"Filed" means, unless otherwise specified, when the document is actually received by the Clerk of Court. Notwithstanding the foregoing definition, a document filed pursuant to 1 DCMR 2805 shall relate back for purposes of timeliness, if its envelope bears a United States Postal Service post mark, rather than a mark from a private postal meter. *See generally* D.C. Superior Court Civil Rule 15(c).

DEPARTMENT OF MENTAL HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Mental Health, pursuant to the authority set forth in sections 104 and 114 of the Mental Health Service Delivery Reform Act of 2001 (Act), effective December 18, 2001, D.C. Law 14-56; D.C. Official Code §7-1131.04 and 7-1131.14 (2001), respectively, hereby gives notice of the adoption of the following new Chapter 34, of Title 22A of the D.C. Code of Municipal Regulations, entitled Mental Health Rehabilitation Services Provider Certification Standards. Final action to adopt these rules was taken on June 6, 2005. Notice of Emergency and Proposed Rulemaking was published on March 4, 2005 (52 D.C.R. 2145). Chapter 34, Title 22A, DCMR sets forth the rules that the Department of Mental Health shall use to certify community-based providers of mental health rehabilitation services and implement the Medicaid Rehabilitation Option for mental health rehabilitation services. Comments have been received and considered. There have been no substantive changes made to the proposed rules. These rules will be effective on the publication of this notice in the D.C. Register.

These final rules (1) reference the consumer grievance rules and the consent to treatment rules promulgated by the Department of Mental Health since the original publication of Chapter 34; (2) conform the regulations regarding certification and corrective action plans to actual practice; (3) authorize physicians working in an approved psychiatric residency program, and moonlighting physicians working in approved psychiatric residency programs to provide mental health rehabilitation services; (4) clarify the requirements for consumer access to qualified practitioners during a crisis; and (5) clarify the role of the CBI or ACT provider in the coordination of treatment planning for consumers authorized to receive either CBI or ACT services. These final rules also conform the text to the approved version of the amendment to the District of Columbia State Medicaid Plan which authorizes the provision of mental health rehabilitation services that was approved by the Centers for Medicare and Medicaid Services on December 3, 2001 and deemed approved by resolution of the Council of the District of Columbia on April 5, 2002 (PR14-0588, 49 DCR 2409).

Title 22A DCMR is amended by adding the following new Chapter 34:

CHAPTER 34**MENTAL HEALTH REHABILITATION SERVICES PROVIDER
CERTIFICATION STANDARDS****3400 GENERAL PROVISIONS**

- 3400.1 The Department of Mental Health (DMH) entered into a Memorandum of Agreement with the Department of Health, Medical Assistance Administration to implement a Medicaid Rehabilitation Option for the provision of mental health rehabilitative services (MHRs).

3400.2 The purpose of these rules is to set forth the requirements for certification of organizations as DMH-certified MHRS providers by DMH.

3400.2 Each DMH-certified MHRS provider shall meet and adhere to the terms and conditions of its Human Care Agreement with DMH and its Medicaid provider agreement with MAA.

3401 **MHRS PROVIDER CERTIFICATION PROCESS**

3401.1 Each applicant seeking certification as an MHRS provider shall submit a certification application to DMH. A DMH-certified MHRS provider seeking renewal of certification shall submit a certification application at least ninety (90) days prior to the termination of its current certification. The certification of an MHRS provider that has submitted a timely application for renewal certification shall continue until DMH takes action to renew or deny renewal of certification.

3401.2 Upon receipt of a certification application, DMH shall review the certification application to determine if it is complete. If a certification application is incomplete, DMH shall return the incomplete certification application to the applicant. An incomplete certification application shall not be regarded as a certification application, and return of the incomplete certification application and DMH's failure to take further action to issue certification to the applicant shall not constitute denial of an application for certification or renewal of certification.

3401.3 Following DMH's acceptance of the certification application, DMH shall determine whether the applicant's services and activities meet the certification standards described in this Chapter. DMH shall schedule and conduct an on-site survey of the applicant's services to determine whether the applicant satisfies all the certification standards.

3401.4 DMH may conduct an on-site survey at the time of certification application or certification renewal, or at any other time with appropriate notice, and shall have access to all records necessary to verify compliance with certification standards, and may conduct interviews with staff, others in the community, and consumers with consumer permission.

3401.5 DMH shall issue certification to each applicant complying with the certification standards. DMH shall issue certification to each DMH-certified MHRS provider seeking renewal of certification that complies with the certification standards.

3401.6 An applicant or DMH-certified MHRS provider that fails to comply with the certification standards shall receive a corrective measures plan (CMP) from DMH within thirty (30) working days, after the conclusion of the on-site survey. The CMP shall describe the areas of non-compliance, suggest actions needed to bring operations into compliance with the certification standards, and set forth a timeframe for the submission of a written corrective action plan (CAP).

- 3401.7 An applicant or DMH-certified MHRS provider's CAP shall describe the actions to be taken and specify a timeframe for correcting the areas of non-compliance with the certification standards. The CAP shall be submitted to DMH within ten (10) working days after receipt of the CMP from DMH.
- 3401.8 DMH shall notify the applicant or DMH-certified MHRS provider whether the provider's CAP is accepted within five (5) working days after receipt.
- 3401.9 DMH shall issue certification after DMH verifies that the applicant or DMH-certified MHRS provider has complied with its CAP and meets all the certification standards.
- 3401.10 If a DMH-certified MHRS provider adds an MHRS service during the term of certification, the MHRS provider shall submit a certification application describing the service. Upon determination by DMH that the service is in compliance with certification standards, DMH shall certify the MHRS provider to provide that service.
- 3401.11 Certification as an MHRS provider shall be two calendar years from the date of issuance of certification by DMH, subject to the MHRS provider's continuous compliance with these certification standards. Certification shall remain in effect until it expires, is renewed or revoked. Certification shall specify the effective date of the certification, whether the MHRS provider is certified as a CSA, sub-provider or specialty provider, and the types of services the MHRS provider is certified to provide.
- 3401.12 Certification is not transferable to any other organization.
- 3401.13 The MHRS provider shall notify DMH immediately of any changes in its operation that affect the MHRS provider's continued compliance with these certification standards, including changes in ownership or control, changes in service and changes in its affiliation and referral arrangements.
- 3401.14 The Director may deny or revoke certification if the applicant or MHRS provider fails to comply with any certification standard.
- 3401.15 Certification shall be considered terminated and invalid if the MHRS provider fails to apply for renewal of certification prior to the expiration date of the certification, voluntarily relinquishes certification, or goes out of business.
- 3402 **SERVICE COVERAGE**
- 3402.1 MHRS are those rehabilitative or palliative services administered by DMH and rendered by DMH-certified MHRS providers to eligible consumers who require such services.

- 3402.2 MHRS are intended for the maximum reduction of mental disability and restoration of a consumer to his or her best possible functional level.
- 3402.3 MHRS are recommended by a physician or a licensed practitioner of the healing arts and rendered by practitioners and clinicians (qualified practitioners) and credentialed staff, under the supervision of qualified practitioners, in certified community mental health rehabilitation services agencies (MHRS providers) in accordance with the certification standards established in this chapter.
- 3402.4 Rehabilitative services covered as MHRS are:
- (a) Diagnostic/Assessment;
 - (b) Medication/Somatic Treatment;
 - (c) Counseling;
 - (d) Community Support;
 - (e) Crisis/Emergency;
 - (f) Rehabilitation/Day Services;
 - (g) Intensive Day Treatment;
 - (h) CBI; and
 - (i) ACT.
- 3402.5 Eligible consumers of MHRS shall meet eligibility requirements established in §3403.
- 3402.6 Eligible MHRS providers include CSAs, sub-providers and specialty providers that are certified in compliance with the certification standards set forth in this chapter.
- 3402.7 Qualified practitioners rendering MHRS through DMH-certified MHRS providers shall meet eligibility requirements described in §3413.
- 3402.8 MHRS coverage limitations are set forth in §3424. Coverage for any MHRS is contingent on whether all of the following criteria are met:
- (a) The service shall be medically necessary;
 - (b) The service shall be delivered by a DMH-certified MHRS provider as described in §3410, §3411 and §3412;

- (c) The service shall be delivered by qualified practitioners (and credentialed staff under the supervision of qualified practitioners) acting within their scope of practice as identified in §3413;
- (d) The service shall be delivered in accordance with an approved IRP/IPC as described in §3407, §3408 and §3409; and
- (e) The service shall be delivered in accordance with the service specific standards set forth in §3414, §3415, §3416, §3417, §3418, §3419, §3420, §3421, §3422 and §3423.

3402.9 All consumers receiving MHRS shall have free choice of MHRS providers and free choice of qualified practitioners delivering services through a DMH-certified MHRS provider, as described in §3406.

3402.10 All consumers receiving MHRS shall have the right to file a grievance with DMH and shall receive fair hearing rights and notice of such rights in accordance with the requirements set forth in 22A DCMR Chapter 3.

3403 **ELIGIBLE CONSUMERS**

3403.1 Eligible consumers of MHRS include children and youth with mental health problems and adults with mental illness as described in D.C. Official Code §7-1131.02(1) and (24) (2001) certified as requiring MHRS by a qualified practitioner.

3403.2 Eligible consumers of MHRS shall have a primary diagnosis on either Axis 1 or 2 of the DSM-IV.

3403.3 Persons with a primary substance abuse diagnosis only are not eligible consumers of MHRS.

3404 **AUTHORIZATION AND RE-AUTHORIZATION OF MHRS**

3404.1 Most MHRS do not require prior authorization by DMH, although some require re-authorization after specified amounts of services have been delivered. Prior authorization and re-authorization requirements are described in §3424.

3404.2 For services requiring either prior authorization or re-authorization under §3424, the CSA shall submit an authorization plan request to DMH for review and approval.

3404.3 Upon receiving the authorization plan request, DMH shall determine whether MHRS are medically necessary and issue a service authorization decision to the CSA.

- 3404.4 As part of the service authorization process, DMH may review the consumer's IRP/IPC or other clinical material if additional clinical information is required in order to evaluate consumer needs and make a level of care determination.
- 3405 **CONSUMER PROTECTIONS**
- 3405.1 Each MHRS provider shall establish and adhere to a consumer rights policy authorized by its governing authority (Consumer Rights Policy) that complies with the requirements of 22A DCMR §301.1.
- 3405.2 Each MHRS provider shall establish and adhere to a system for distributing the Consumer Rights Policy that complies with the requirements of 22A DCMR §301.2.
- 3405.3 Each MHRS provider shall establish and adhere to a well-publicized complaint and grievance system, which includes written policies and procedures for handling consumer, family, and practitioner complaints and grievances that complies with 22A DCMR §306 (Complaint and Grievance Policy).
- 3405.4 Each MHRS provider shall establish and adhere to policies and procedures for obtaining written informed consent to treatment from consumers (Consent to Treatment Policy), which comply with applicable federal and District laws and regulations, including 22A DCMR Chapter 1.
- 3405.5 Each MHRS provider shall establish and adhere to policies and procedures governing the release of mental health information about consumers (Release of Consumer Information Policy), which comply with applicable federal and District laws and regulations. For consumers with co-occurring psychiatric and addictive disorders, the MHRS provider shall comply with the requirements of 42 CFR Part 2 governing the confidentiality and release of drug and alcohol treatment records.
- 3405.6 Each MHRS provider shall establish and adhere to policies and procedures governing the use of advance instructions for mental health treatment, durable power of attorney for health care and advance directives that comply with applicable federal and District laws and regulations, including 22A DCMR Chapter 1 and DMH policy (Advance Instructions Policy).
- 3405.7 Each MHRS provider's Advance Instructions Policy shall require qualified practitioners to incorporate the development of advance instructions for mental health treatment, durable power of attorney for health care, and advance directives into the IRP/IPC planning process.
- 3405.8 DMH shall review and approve each MHRS provider's Consumer Rights Statement, Complaint and Grievance Policy, Consent to Treatment Policy, Release of Consumer Information Policy and Advance Instructions Policy, during the certification process.

3406 CONSUMER CHOICE

- 3406.1 Each MHRS provider shall establish and adhere to policies and procedures governing the means by which consumers shall be informed of the full choices of MHRS providers, qualified practitioners and other mental health service providers available, including information about peer support and family support services and groups and how to access these services (MH Consumer Choice Policy).
- 3406.2 DMH shall review and approve each MHRS provider's MH Consumer Choice Policy during the certification process.
- 3406.3 The MH Consumer Choice Policy shall comply with applicable federal and District laws and regulations.
- 3406.4 Each MHRS provider shall:
- (a) Make its MH Consumer Choice Policy available to consumers and their families; and
 - (b) Establish and adhere to a system for documenting that consumers and families receive the MH Consumer Choice Policy.
- 3406.5 Each CSA's MH Consumer Choice Policy shall ensure that each enrolled consumer:
- (a) Requesting MHRS directly from the CSA is informed that the consumer may choose to have MHRS provided by any of the other DMH-certified CSAs;
 - (b) Enrolled in the CSA is informed that the consumer may choose to have MHRS provided by any of the DMH-certified sub-providers that have entered into affiliation agreements with that CSA;
 - (c) Enrolled in the CSA is informed that the consumer may choose to have MHRS provided by any of the qualified practitioners employed by or contracted by the CSA to provide MHRS, including qualified practitioners providing MHRS through one of the CSA's subcontractors; and
 - (d) Enrolled in the CSA is informed that the consumer may choose to have MHRS provided by any of the DMH-certified specialty providers that have entered into affiliation agreements with that CSA.
- 3406.6 Each sub-provider's MH Consumer Choice Policy shall ensure that each consumer:
- (a) Enrolled in a CSA requesting MHRS directly from the sub-provider is directed to that CSA for Diagnostic/Assessment and IRP/IPC development and approval;

- (b) Not enrolled in a CSA and requesting MHRS directly from the sub-provider is directed to DMH's Consumer Enrollment and Referral System; and
- (c) Enrolled in a CSA and referred by that CSA to the sub-provider for MHRS is informed that the consumer may choose to have MHRS provided by any of the qualified practitioners employed by or contracted by the sub-provider to provide MHRS, including the sub-provider's subcontractors.

3406.7 Each specialty provider's MH Consumer Choice Policy shall ensure that each consumer:

- (a) Enrolled in a CSA requesting MHRS directly from the specialty provider is directed to that CSA for Diagnostic/Assessment and IRP/IPC development and approval;
- (b) Not enrolled in a CSA and requesting MHRS directly from the specialty provider is directed to DMH's Consumer Enrollment and Referral System; and
- (c) Enrolled in a CSA and referred by that CSA to the specialty provider for MHRS is informed that the consumer may choose to have MHRS provided by any of the qualified practitioners employed by or contracted by the specialty provider to provide MHRS, including the specialty provider's subcontractors.

3407 **TREATMENT PLANNING PROCESS**

3407.1 Each CSA shall coordinate the treatment planning process for its enrolled consumers, except that the treatment planning process for consumers authorized to receive:

- (a) CBI shall be coordinated by the consumer's CBI provider; and
- (b) ACT services shall be coordinated by the consumer's ACT provider.

3407.2 The treatment planning process for consumers shall, at a minimum, include:

- (a) The completion of a Diagnostic/Assessment service and required components as described in §3415;
- (b) Development of an IRP/IPC as described in §3408;
- (c) Development of an ISSP by each subprovider providing Medication/Somatic Treatment, Counseling or Community Support to the consumer as described in §3409 and required by the IRP/IPC;

- (d) Development of an ISSP by each specialty provider providing Rehabilitation/Day Services, Intensive Day Treatment, CBI or ACT to the consumer as described in §3409 and required by the IRP/IPC; and
- (e) Consideration of the consumer's beliefs, values and cultural norms in how, what and by whom MHRS are to be provided.

3407.3 Court-appointed guardians for adults, children and youth and the parents or family members of children and youth shall be involved in the treatment planning process. The families and significant others of adult consumers may participate in the treatment planning process to the extent that the adult consumer consents to the involvement of family and significant others.

3408 **IRP/IPC DEVELOPMENT AND IMPLEMENTATION**

3408.1 The IRP/IPC shall serve as authorization for the provision of MHRS and for the development of any ISSP required by the IRP/IPC. Certain services require pre-authorization or authorization by DMH, prior to commencement of the treatment planning process. All services, including those that require pre-authorization or authorization by DMH shall be addressed in the IRP/IPC.

3408.2 The IRP/IPC shall serve as certification that the MHRS are medically necessary as indicated by the approving practitioner's signature on the initial and subsequent IRP/IPC. The approving practitioner's approval of an IRP/IPC shall occur by the fourth visit or within thirty (30) calendar days after the consumer enrolls with the CSA, whichever occurs first.

3408.3 Each CSA shall develop and maintain a complete and current IRP/IPC for each enrolled consumer.

3408.4 Development of the IRP/IPC shall commence after the first clinical contact with the consumer, so that payment may be made for MHRS delivered consistent with the initial IRP/IPC. Consumers in a crisis situation who are eligible for ACT, CBI or Crisis/Emergency shall receive such services while the IRP/IPC is being developed.

3408.5 The IRP/IPC shall include the following elements:

- (a) A description of the consumer's strengths or assets and challenges and how the consumer's strengths and assets will be utilized in achieving treatment goals.
- (b) A statement of the mutually desired overall long-term results of each intervention, intermediate steps to be taken to achieve those long-term results and the overall treatment being provided for the consumer (Treatment Goals). Treatment Goals shall be based on the consumer's expressed needs and needs identified through Diagnostic/Assessment services, and referral information.

- (c) A statement of the specific consumer or family skills that need to be developed or improved. This statement shall identify services and resources that need to be changed or modified to achieve each Treatment Goal (Objectives). Objectives shall be stated in terms of attainable and measurable results.
- (d) A description of the interventions to be used to achieve each Objective and Treatment Goal including, but not limited to:
 - (1) A staff position or service component responsible for the intervention;
 - (2) The names of other agencies (and other human services systems if applicable) providing services for the consumer, a description of the service being provided, identification by name and title of the staff persons of those agencies or systems of care responsible for providing such services, and evidence of interagency service coordination;
 - (3) The intervention by service type, with the IRP/IPC identifying all services related to the provision of mental health services, regardless of the payment source for the service;
 - (4) The frequency and duration of the interventions;
 - (5) For each service, the MHRS provider chosen by the consumer; and
 - (6) A plan for addressing any medical problems that significantly impact or could be expected to affect the consumer's functioning which is to be carried out by either the CSA or another health-providing organization or practitioner.
- (e) Development of psychiatric advance instructions, advance directives, crisis prevention plan, and relapse prevention plan.

- 3408.6 The clinical manager shall discuss the IRP/IPC with the consumer on an ongoing basis.
- 3408.7 Specific information describing the consumer's response to, participation in and agreement to the IRP/IPC shall be recorded in the consumer's clinical record.
- 3408.8 The clinical manager shall document the consumer's participation in the development of the IRP/IPC by obtaining the consumer's signature on the IRP/IPC, and documenting the consumer's own words used to communicate with the Diagnostic/Assessment Team. A court-appointed guardian for adults, children and youth and the parent or family member of children and youth consumers may sign the IRP/IPC, if required by District laws and regulations.

- 3408.9 In situations where the consumer does not demonstrate the capacity to sign or does not sign the IRP/IPC, the reasons the consumer does not sign shall be recorded in the consumer's clinical record, including each date where signature was attempted.
- 3408.10 The approving practitioner and the clinical manager shall sign the IRP/IPC.
- 3408.11 The clinical manager has an affirmative obligation to ask the consumer to document participation and agreement with the IRP/IPC at each subsequent encounter if the consumer did not sign the IRP/IPC.
- 3408.12 Documentation of participation of the consumer's court-appointed guardian, family and significant others in the development of the IRP/IPC shall also be included in the consumer's clinical record, as appropriate.
- 3408.13 Each MHRS provider shall develop policies and procedures for IRP/IPC review (IRP/IPC Review Policy). The IRP/IPC Review Policy shall be part of the MHRS provider's Treatment Planning Policy as required by §3410.12.
- 3408.14 The IRP/IPC Review Policy shall require that the IRP/IPC be reviewed and updated every ninety (90) days and any time there is a significant change in the consumer's condition or situation to reflect progress toward or the lack of progress toward the Treatment Goals. The IRP/IPC may be reviewed more frequently, as necessary, based on the consumer's progress or circumstances.
- 3408.15 Each IRP/IPC review shall include a review of each of the items stated in §3408.5 including progress on Treatment Goals, re-identification of strengths and progress on Objectives.
- 3408.16 The consumer, the consumer's clinical manager, approving practitioner and other qualified practitioners as necessary or appropriate shall establish new Objectives and modify, add or delete Treatment Goals based on the results of the IRP/IPC review, the consumer's assessment of progress toward meeting Treatment Goals and any new needs, and any other assessments provided by significant others, family or other professionals.
- 3408.17 At least the approving practitioner and the consumer shall participate in the IRP/IPC review.
- 3408.18 At the IRP/IPC review, the approving practitioner shall identify all required MHRS re-authorizations and establish a target date for requesting the re-authorizations well in advance of their expiration dates.
- 3408.19 The approving practitioner shall document the consumer's participation in the IRP/IPC review by obtaining the consumer's signature on the revised IRP/IPC. A court-appointed guardian for adults, children and youth and the parent or family

member of children and youth consumers may be required to sign the revised IRP/IPC, if required by District laws and regulations.

- 3408.20 Documentation of participation of the consumer's court-appointed guardian, family and significant others in the review of the IRP/IPC shall also be included in the consumer's clinical record, as appropriate.

3409 **ISSP DEVELOPMENT AND IMPLEMENTATION**

- 3409.1 An ISSP shall be developed by each subprovider providing Medication/Somatic Treatment, Counseling, or Community Support to the consumer, and by each specialty provider providing Rehabilitation/Day Services, Intensive Day Treatment, CBI, or ACT if the IRP/IPC requires the consumer receive such service. The ISSP shall be developed within the time specified in the rules governing the specific service.
- 3409.2 The ISSP shall identify each service intervention and specify the service amount, duration, scope, and frequency consistent with the consumer's IRP/IPC. The ISSP shall describe Treatment Goals, Objectives, and interventions to be used to achieve Treatment Goals and Objectives and the methods for determining effectiveness of the ISSP.
- 3409.3 Specific information describing the consumer's response to, participation in, and agreement to the ISSP shall be recorded.
- 3409.4 The sub-provider or specialty provider shall document the consumer's participation in the development of the ISSP by obtaining the consumer's signature on the ISSP and documenting of consumer's own words used to communicate with the Diagnostic/Assessment Team. A court-appointed guardian for adults, children and youth and the parent or family member of children and youth consumers may be required to sign the ISSP, if required by District laws and regulations.
- 3409.5 In situations where the consumer does not demonstrate the capacity to sign or does not sign the ISSP, the reasons the consumer does not sign shall be recorded in the consumer's clinical record, including each date where signature was attempted.
- 3409.6 The approving practitioner has an affirmative obligation to ask the consumer to document participation and agreement with the ISSP at each subsequent encounter if the consumer did not sign the ISSP.
- 3409.7 Documentation of participation of the consumer's court-appointed guardian, family and significant others in the development of the ISSP shall also be included in the consumer's clinical record, as appropriate.
- 3409.8 Each sub-provider providing Medication/Somatic Treatment, Counseling, or Community Support, and each specialty provider providing Rehabilitation/Day

Services, Intensive Day Treatment, CBI, or ACT shall develop policies and procedures for the ISSP review (ISSP Review Policy). The ISSP Review Policy shall be part of the sub-provider or specialty provider's Treatment Planning Policy as required by §3410.12.

- 3409.9 The ISSP Review Policy shall require that review of each ISSP for a consumer occurs concurrently with the IRP/IPC review. At a minimum, the ISSP review shall occur every ninety (90) days and the ISSP Review Policy shall require that the ISSP review demonstrate how the ISSP is used to modify or change Treatment Goals, Objectives and interventions, consistent with the IRP/IPC.

3410 MHRS PROVIDER QUALIFICATIONS – GENERAL

- 3410.1 Each MHRS provider shall be established as a legally recognized entity in the United States and qualified to conduct business in the District. A certificate of good standing issued by the District of Columbia Department of Consumer and Regulatory Affairs shall be evidence of qualification to conduct business.

- 3410.2 Each MHRS provider shall maintain the clinical operations policies and procedures described in this section, which shall be reviewed and approved by DMH, during the certification survey process.

- 3410.3 Each MHRS provider shall:

- (a) Have a governing authority, which shall have overall responsibility for the functioning of the MHRS provider;
- (b) Comply with all applicable federal and District laws and regulations;
- (c) Hire personnel with the qualifications necessary to provide MHRS and to meet the needs of its enrolled consumers;
- (d) Ensure that qualified practitioners, listed in §3413, are available to provide appropriate and adequate supervision of all clinical activities; and
- (e) Employ qualified practitioners that meet all professional requirements as defined by the District's licensing laws and regulations relating to the profession of the qualified practitioner.

- 3410.4 Each MHRS provider shall establish and adhere to policies and procedures for selecting and hiring staff (Staff Selection Policy), including, but not limited to requiring:

- (a) Evidence of licensure, certification or registration as applicable and as required by the job being performed;

- (b) For unlicensed staff, evidence of completion of an appropriate degree, training program, or credentials, such as academic transcripts or a copy of degree;
- (c) Appropriate reference and background checks as required by federal and District of Columbia law;
- (d) Evidence of completion of all communicable disease testing required by District laws and regulations, including a Tuberculin skin test or a chest x-ray;
- (e) A process by which all staff, as a condition of hiring, shall:
 - (1) Declare any past events that might raise liability or risk management concerns, such as malpractice actions, insurance cancellations, criminal convictions, Medicare/Medicaid sanctions, and ethical violations;
 - (2) Indicate whether they are presently using illegal drugs; and
 - (3) Attest that they are capable of performing the essential functions of their jobs, with or without accommodation; and
- (f) A mechanism for ongoing monitoring of staff licensure, certification, or registration, such as an annual confirmation process concurrent with staff performance evaluations that includes repeats of screening checks outlined above as appropriate.

3410.5 Each MHRS provider shall establish and adhere to written job descriptions for all positions, including, at a minimum, the role, responsibilities, reporting relationships, and minimum qualifications for each position. The minimum qualifications for each position shall be appropriate for the scope of responsibility and clinical practice described for each position.

3410.6 Each MHRS provider shall establish and adhere to policies and procedures requiring a periodic evaluation of clinical and administrative staff performance (Performance Review Policy) that require an assessment of clinical competence, as well as general organizational work requirements, and an assessment of key functions as described in the job description.

3410.7 Each MHRS provider shall establish and adhere to policies and procedures to ensure that clinical staff are licensed and to the extent required by applicable District laws and regulations, work under the supervision of a qualified practitioner (Supervision and Peer Review Policy). The Supervision and Peer Review Policy shall:

- (a) Include procedures for clinical supervision, which require sufficient clinical supervision conducted by qualified practitioners;

- (b) Require personnel files of non-licensed clinical staff and consumer clinical records to contain evidence that the Supervision and Peer Review Policy is observed; and
- (c) Include an active peer review process to monitor quality of care delivered by qualified practitioners and credentialed staff.

3410.8 Each MHRS provider shall establish and adhere to policies and procedures governing the credentialing or privileging of staff (Credentialing Policy) consistent with DMH rules on privileging and competency-based credentialing systems. The Credentialing Policy shall:

- (a) Allow staff who do not possess college degrees to be credentialed for direct service work, based on educational equivalent qualifications which include experience that provides an individual with an understanding of mental illness and which was acquired as an adult through personal experience with the mental health treatment system and recovery or through the provision of significant supports to adults with mental illness or children and youth with mental health problems and with serious emotional disturbance;
- (b) Facilitate the employment of persons in recovery as peer counselors and members of community support teams; and
- (c) Include an assessment of qualified practitioners' cultural competence.

3410.9 Each MHRS provider shall provide training to all staff, including all qualified practitioners (both those employed and those under contract to the MHRS provider), as orientation to MHRS (Staff Orientation Training) during the first three (3) months of employment and on an ongoing basis. The Staff Orientation Training curriculum shall address the following:

- (a) Mental illnesses and evidence-based clinical interventions;
- (b) Consumer rights;
- (c) Declaration of advance instructions for mental health treatment, durable power of attorney for health care, and advance directives;
- (d) Definitions and types of abuse and neglect and the MHRS provider's policies on investigating allegations of abuse and neglect;
- (e) Recovery model, psychiatric rehabilitation, consumer and family empowerment, and self-help or peer support;
- (f) Knowledge of medication, its benefits, and side effects;

- (g) Child-centered, family-focused, and multi-system service delivery;
- (h) Communication skills;
- (i) Integrated treatment for co-occurring psychiatric and addictive disorders;
- (j) Behavior management;
- (k) Handling emergency situations;
- (l) Recordkeeping and clinical documentation standards;
- (m) Confidentiality;
- (n) DMH Consumer Enrollment and Referral System;
- (o) MHRS provider's policies and procedures;
- (p) Medicaid MHRS requirements, especially those relating to recordkeeping, billing, documentation, and consumer choice; and
- (q) Cultural competence and its relationship to treatment outcomes.

3410.10 Each MHRS provider shall establish and adhere to an annual training plan for staff to ensure that all staff receive at a minimum, annual training on the following topics (Annual Training Plan):

- (a) The subjects covered during Staff Orientation Training;
- (b) Infection control guidelines, including compliance with the bloodborne pathogens standard, communicable diseases and universal precautions;
- (c) Safety and risk management; and
- (d) The MHRS provider's Disaster Evacuation Plan.

3410.11 Each MHRS provider shall establish and adhere to policies and procedures defining pre-admission, intake, screening, referral, transfer, and discharge procedures (Admission, Transfer, and Discharge Policy) that comply with applicable federal and District laws and regulations.

3410.12 Each MHRS provider shall establish and adhere to policies and procedures governing the coordination of the treatment planning process (Treatment Planning Policy), including procedures for designing, implementing, reviewing, and revising each consumer's IRP/IPC and ISSPs that comply with the requirements of §3407, §3408 and §3409.

- 3410.13 Each MHRS provider shall establish and adhere to policies and procedures requiring that treatment be provided in accordance with the service specific standards in §3414, §3415, §3416, §3417, §3418, §3419, §3420, §3421 and §3422 (Service Specific Policy). The Service Specific Policy shall:
- (a) Address supervision requirements and required caseload ratios that are appropriate to the population served and treatment modalities employed; and
 - (b) Include a written description of the services offered by the MHRS provider (Service Description) describing the purpose of the service, the hours of operation, the intended population to be served, treatment modalities provided by the service, treatment objectives, and expected outcomes.
- 3410.14 Each MHRS provider shall establish and adhere to policies and procedures governing communication with the consumer's primary care providers (Primary Care Provider Communication Policy). The Primary Care Provider Communication Policy shall:
- (a) Require the MHRS provider to obtain and document authorization from the consumer in the consumer's clinical records before contacting the consumer's primary care providers;
 - (b) Outline the MHRS provider's interface with primary health care providers, managed health care plans, and other providers of mental health services; and
 - (c) Describe the MHRS provider's activities which will enhance consumer access to primary health care and the coordination of mental health and primary health care services.
- 3410.15 Each MHRS provider shall establish and adhere to policies and procedures for handling routine, urgent, and emergency situations (Unscheduled Service Access Policy). The Unscheduled Service Access Policy shall:
- (a) Include referral procedures to local emergency departments;
 - (b) Include staff assignment to cover emergency walk-in hours;
 - (c) Include on-call arrangements for clinical staff and physicians that provide for both:
 - (1) Direct telephone access to a qualified practitioner, for the consumer, including an employee of an emergency services provider selected by the consumer or other person acting on behalf of the consumer making contact with the MHRS provider; and
 - (2) Timely access to face-to-face crisis support services;

- (d) Specify how the MHRS provider will interact and coordinate services with the DMH-designated crisis and emergency service; and
- (e) Include procedures for triaging consumers who require Crisis/Emergency services or psychiatric hospitalization.

3410.16

Each MHRS provider shall establish and adhere to policies and procedures for clinical record documentation, security, and confidentiality of consumer and family information, clinical records retention, maintenance, purging and destruction, and for disclosure of consumer and family information, and informed consent that comply with applicable federal and District laws and regulations (Clinical Records Policy). The Clinical Records Policy shall:

- (a) Require the MHRS provider to maintain all clinical records in a secured and locked storage area;
- (b) Require the MHRS provider to maintain and secure a current, clear, organized, and comprehensive clinical record for every individual assessed, treated, or served which includes information deemed necessary to provide treatment, protect the MHRS provider, or comply with applicable federal and District laws and regulations; and
- (c) Require that the clinical record contain information to identify the consumer, support the diagnosis, justify the treatment, document the course and results of treatment, and facilitate continuity of care. The clinical record shall include, at a minimum:
 - (1) Consumer identification information, including enrollment information;
 - (2) Identification of a person to be contacted in the event of emergency;
 - (3) Basic screening and intake information;
 - (4) Documentation of internal or external referrals;
 - (5) Comprehensive diagnostic and psychosocial assessments;
 - (6) Pertinent medical information including the name, address, and telephone number of the consumer's primary care physician and the name and address of the consumer's preferred hospital;
 - (7) Advance instructions and advance directives;
 - (8) The IRP/IPC and ISSP as appropriate;

- (9) For children and youth, documentation of family involvement in treatment planning and services or statement of reasons why it is not clinically indicated;
- (10) Methods for addressing consumers' and families' special needs, especially those which relate to communication, cultural, and social factors;
- (11) Detailed description of services provided;
- (12) Progress notes;
- (13) Discharge planning information;
- (14) Appropriate consents for service;
- (15) Appropriate release of information forms; and
- (16) Signed Consumer Rights Statement.

3410.17 Progress notes shall:

- (a) Be written at least once per month and as needed;
- (b) Reflect IRP/IPC and ISSP implementation, including documentation of the choices and perceptions of the consumer regarding the service(s) provided; and
- (c) Be signed and dated by the credentialed staff or qualified practitioner making the entry. A qualified practitioner shall countersign progress notes made by credentialed staff.

3410.18 Each MHRS provider shall develop and maintain sufficient written clinical documentation to support each therapy, service, activity, or session for which billing is made which, at a minimum, consists of:

- (a) The specific service type rendered;
- (b) The date, duration, and actual time, a.m. or p.m. (beginning and ending), during which the services were rendered;
- (c) Name, title, and credentials of the person providing the services;
- (d) The setting in which the services were rendered;
- (e) Confirmation that the services delivered are contained in the consumer's IRP/IPC;

- (f) A description of each encounter or service by a qualified practitioner or credentialed staff with the consumer which is sufficient to document that the service was provided in accordance with this Chapter; and
- (g) Dated and authenticated entries, with their authors identified, which are legible and concise, including the printed name and the signature of the person rendering the service, diagnosis and clinical impression recorded in the terminology of the ICD-9 CM, the service provided and the signature of a qualified practitioner with authority to diagnose.

3410.19 Each MHRS provider shall ensure that all clinical records of consumers are completed promptly, filed, and retained in accordance with the MHRS provider's Clinical Records Policy.

3410.20 MHRS providers shall make MHRS available as follows:

MHRS	HOURS OF OPERATION	OTHER AVAILABILITY REQUIREMENTS
Diagnostic/Assessment	Six (6) days per week 9:00 am – 6:00 p.m., 3 days per week 9:00 am – 9:00 p.m., 2 days per week 4 hours on Saturday	CSA shall operate an on-call system for enrolled consumers, twenty-four (24) hours per day, seven (7) days per week.
Medication/Somatic Treatment	Six (6) days per week 9:00 am – 6:00 p.m., 3 days per week 9:00 am – 9:00 p.m., 2 days per week 4 hours on Saturday	CSA shall operate an on-call system for enrolled consumers, twenty-four (24) hours per day, seven (7) days per week.
Counseling	Six (6) days per week 9:00 am – 6:00 p.m., 3 days per week 9:00 am – 9:00 p.m., 2 days per week 4 hours on Saturday	CSA shall operate an on-call system for enrolled consumers, twenty-four (24) hours per day, seven (7) days per week.
Community Support	Twenty-four (24) hours per day, Seven (7) days per week	CSA shall operate an on-call system for enrolled consumers, twenty-four (24) hours per day, seven (7) days per week. Seventy-five percent (75%) or more of services shall be performed face-to-face. At least fifty percent (50%) of staff time shall be spent working outside the service site(s) with or on behalf of consumers.

MHRS	HOURS OF OPERATION	OTHER AVAILABILITY REQUIREMENTS
Crisis/Emergency	Twenty-four (24) hours per day, Seven (7) days per week	Psychiatric consultation shall be available twenty-four (24) hours per day, seven (7) days per week
Rehabilitation/Day Services	Thirty (30) hours per week, no less than six (6) hours per day	Consumers authorized and referred for service shall be admitted within seven (7) business days of the referral from the CSA.
Intensive Day Treatment	Seven (7) days per week, no less than five (5) hours per day	Programs serving adults shall offer a minimum of forty (40) hours of active programming per week. Programs serving children shall offer a minimum of thirty (30) hours of active programming per week. Consumers authorized and referred for Intensive Day Treatment shall be admitted within forty-eight (48) hours of referral by a CSA.
Community-Based Intervention	Twenty-four (24) hours per day, Seven (7) days per week	Consumers authorized and referred for CBI shall be admitted within forty-eight (48) hours of referral by a CSA. A CBI Team member shall respond to a call from family or a significant other, either by telephone or face-to-face contact within sixty (60) minutes of receiving the call.

MHRS	HOURS OF OPERATION	OTHER AVAILABILITY REQUIREMENTS
Assertive Community Treatment	Twenty-four (24) hours per day, Seven (7) days per week, with emergency response coverage, to include psychiatric availability	Consumers authorized and referred for ACT shall be admitted within forty-eight (48) hours of referral by a CSA. At least sixty percent (60%) of ACT Services shall be provided in locations other than the office, according to consumer need, preference and clinical appropriateness. An ACT team member shall respond to a call from family or a significant other, either by telephone or face-to-face contact within sixty (60) minutes of receiving the call.

3410.21 Each MHRS provider shall establish and adhere to policies and procedures requiring the MHRS provider to make language interpreters available as needed for persons who do not use English as a first language or use a non-primary language for communication (Interpreter Policy). The Interpreter Policy shall:

- (a) Prohibit a person acting as a language interpreter from simultaneously functioning as a qualified practitioner, in either individual treatment or treatment planning sessions;
- (b) Address the employment of qualified sign language interpreters.

3410.22 The Interpreter Policy shall allow staff and contractors who do not possess valid certification from the National Registry of Interpreters for the Deaf to be credentialed based on skills in mental health interpreting gained through supervised experience. For purposes of this rule, supervised experience shall include supervision by an interpreter certified by the National Registry of Interpreters for the Deaf and ongoing training in sign language interpreting, preferably related to mental health, and may include on-the-job learning prior to employment by the MHRS provider.

3410.23 Each MHRS provider shall utilize a TTY communications line (or an equivalent) to enhance the MHRS provider's ability to respond to service requests and needs of consumers and potential consumers. MHRS provider staff shall be trained in the use of such communication devices.

- 3410.24 Each MHRS provider shall establish and adhere to policies and procedures which govern the provision of services in natural settings (Natural Settings Policy). The Natural Settings Policy shall require the MHRS provider to document how it respects consumers' and families' right to privacy and confidentiality when services are provided in natural settings.
- 3410.25 Each MHRS provider shall establish and adhere to policies and procedures and an in-service training program for all staff regarding sensitivity to cultural issues, increasing cultural competence of all staff, and treating consumers with dignity and respect, addressing the following areas: beliefs, values, tradition, lifestyle practices, laws and regulations, formal and informal rules of behavior, spirituality, poverty, powerlessness, patienthood and disability (Cultural Competence Policy). Personnel files of all staff shall contain documentation that, at a minimum, eight (8) hours of training is completed annually, and that the training follows DMH's recommended curriculum for cultural sensitivity. Each MHRS provider shall ensure that services are delivered in a culturally sensitive manner.
- 3410.26 Each MHRS provider shall establish and adhere to anti-discrimination policies and procedures relative to hiring, promotion, and provision of services to consumers that comply with applicable federal and District laws and regulations (Anti-Discrimination Policy).
- 3410.27 Each MHRS provider shall establish and adhere to policies and procedures governing quality improvement (Quality Improvement Policy). The Quality Improvement Policy shall require the MHRS provider to adopt a written Quality Improvement (QI) plan describing the objectives and scope of its QI program and requiring MHRS provider staff, consumer, and family involvement in the QI program. DMH shall review and approve each MHRS provider's QI program. The QI program shall be operational and shall measure and ensure at least the following:
- (a) Access and availability of services;
 - (b) Treatment and prevention of acute and chronic conditions;
 - (c) High volume services, high risk conditions and services, especially children and youth services;
 - (d) Coordination of care across behavioral health treatment and primary care treatment settings;
 - (e) Compliance with all MHRS certification standards;
 - (f) Adequacy, appropriateness and quality of care;
 - (g) Efficient utilization of resources; and
 - (h) Consumer and family satisfaction with services.

3410.28 Each MHRS provider shall comply with the following requirements for facilities management:

- (a) Each MHRS provider's service site(s) shall be located and designed to provide adequate and appropriate facilities for private, confidential individual and group counseling sessions in consumer interview rooms.
- (b) Each MHRS provider's service site(s) shall have appropriate space for group activities and educational programs.
- (c) All areas of the MHRS provider's service site(s) shall be kept clean and safe, and shall be appropriately equipped and furnished for the services delivered.
- (d) In-office waiting time shall be less than one (1) hour from the scheduled appointment time. Each MHRS provider shall demonstrate that it can document the time period for in-office waiting.
- (e) Each MHRS provider shall comply with applicable provisions of the Americans with Disabilities Act in all business locations.
- (f) Each MHRS provider's main service site shall be located within reasonable walking distance of public transportation.
- (g) Each MHRS provider shall establish and adhere to a written evacuation plan to be used in fire, natural disaster, medical emergencies, bomb threats, terrorist attacks, violence in the work place, or other disaster for all service sites (Disaster Evacuation Plan).
- (h) The Disaster Evacuation Plan shall require the MHRS provider:
 - (1) To conduct periodic disaster evacuation drills;
 - (2) Ensure that all evacuation routes are clearly marked by lighted exit signs; and
 - (3) Ensure that all staff participate in annual training about the Disaster Evacuation Plan and disaster response procedures.
- (i) Each MHRS provider shall obtain a written certificate of compliance from the District of Columbia Department of Fire and Emergency Medical Services indicating that all applicable fire and safety code requirements have been satisfied.
- (j) Each MHRS provider shall provide physical facilities for all service site(s) which are structurally sound and which meet all applicable federal and

District laws and regulations for adequacy of construction, safety, sanitation and health.

- (k) Each MHRS provider shall establish and adhere to policies and procedures governing infection control (Infection Control Policy). The Infection Control Policy shall comply with applicable federal and District laws and regulations, including, but not limited to the bloodborne pathogens standard set forth in 29 CFR § 1910.1030.
- (l) Each MHRS provider shall establish and adhere to policies and procedures governing the purchasing, receipt, storage, distribution, return, and destruction of medication that include accountability for and security of medications located at any of its service site(s) (Medication Policy). The Medication Policy shall comply with applicable federal and District laws and regulations regarding the purchasing, receipt, storage, distribution, dispensing, return, and destruction of medications and require the MHRS provider to maintain all medications and prescription blanks in a secured and locked area.

3410.29 Each MHRS provider shall have established by-laws or other legal documentation regulating the conduct of its internal financial affairs. This documentation shall clearly identify the individual(s) that are legally responsible for making financial decisions for the MHRS provider and the scope of such decision-making authority. Each MHRS provider shall:

- (a) Maintain an accounting system that conforms to generally acceptable accounting principles, provides for adequate internal controls, permits, the development of an annual budget, an audit of all income received and an audit of all expenditures disbursed by the MHRS provider in the provision of services;
- (b) Have an internal process that allows for the development of interim and annual financial statements that compares actual income and expenditures with budgeted amounts, accounts receivable, and accounts payable information; and
- (c) Operate in accordance with an annual budget established by its governing authority.

3410.30 Each MHRS provider shall establish and adhere to policies and procedures governing the retention, maintenance, purging and destruction of its business records (Records Retention Policy). The Records Retention Policy shall:

- (a) Comply with applicable federal and District laws and regulations;
- (b) Require the MHRS provider to maintain all business records pertaining to costs, payments received and made, and services provided to consumers

for a period of six (6) years or until all audits are completed, whichever is longer; and

- (c) Require the MHRS provider to allow DMH, MAA, the District's Inspector General, the United States Department of Health and Human Services, the Comptroller General of the United States or any of their authorized representatives to review the MHRS provider's business records, including clinical and financial records.

3410.31 Each MHRS provider shall comply with the following requirements for maintaining certification, provider status, and contracts:

- (a) Maintain proof of DMH certification;
- (b) Maintain an active Medicaid provider status at all times;
- (c) Document referral arrangements in writing, using the DMH-approved affiliation agreement;
- (d) Maintain copies of contracts with DMH, vendors, suppliers, and independent contractors; and
- (e) Require that its subcontractors continuously comply with the provisions of the MHRS provider's Human Care Agreement with DMH.

3410.32 Each MHRS provider, at its expense, shall:

- (a) Obtain the minimum insurance coverage required by its Human Care Agreement; and
- (b) Make evidence of its insurance coverage available to DMH upon request.

3410.33 Each MHRS provider shall establish and adhere to policies and procedures governing billing and payment for MHRS (Billing and Payment Policy). The Billing and Payment Policy shall require the MHRS provider to have the necessary operational capacity to submit claims, document information on services provided, and track payments received. This operational capacity shall include the ability to:

- (a) Verify eligibility for Medicaid and other third party payers;
- (b) Document MHRS provided (by MHRS provider staff and subcontractors);
- (c) Submit claims and documentation of MHRS to DMH on a timely basis; and
- (d) Track payments for all MHRS provided enrolled or referred consumers.

- 3410.34 Each MHRS provider shall submit claims for MHRS provided to enrolled consumers to DMH within ninety (90) days of the date of service, or thirty (30) days after a secondary or third party payer has adjudicated a claim for this service. DMH shall not pay for a claim that is submitted more than one (1) year from the date of service, except when federal law or regulations would require such payment to be made.
- 3410.35 Each MHRS provider shall have an established sliding fee schedule covering each of the MHRS it provides. For services provided to Medicaid-eligible consumers, no additional charge shall be imposed for services beyond that paid by Medicaid.
- 3410.36 Each MHRS provider shall utilize and require its subcontractors to utilize payments from other public or private sources, including Medicare. Payment of DMH and federal funds to the MHRS provider shall be conditional upon the utilization of all benefits from other payment sources.
- 3410.37 Each MHRS provider shall operate according to all applicable federal and District laws and regulations relating to fraud and abuse in health care, the provision of mental health services, and the Medicaid program. An MHRS provider's failure to report potential or suspected fraud or abuse may result in sanctions, cancellation of contract, or exclusion from participation as an MHRS provider. Each MHRS provider shall:
- (a) Cooperate and assist the District and any federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud and abuse; and
 - (b) Be responsible for promptly reporting suspected fraud and abuse to DMH, taking prompt corrective actions consistent with the terms of any contract or subcontract with DMH, and cooperating with MAA investigations.
- 3410.38 Each MHRS provider shall establish and adhere to a plan for ensuring compliance with applicable federal and District laws and regulations (Corporate Compliance Plan), approved by DMH. Each MHRS provider shall submit any updates or modifications to its Corporate Compliance Plan to DMH for prior review and approval. Each MHRS provider's Corporate Compliance Plan shall:
- (a) Designate an officer or director with responsibility and authority to implement and oversee the operation of the Corporate Compliance Plan;
 - (b) Require that all officers, directors, managers, and employees know and understand its provisions;
 - (c) Include procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of MHRS;

- (d) Include procedures for the confidential reporting of violations of the Corporate Compliance Plan to DMH, including procedures for the investigation and follow-up of any reported violations;
- (e) Ensure that the identities of individuals reporting suspected violations of the Corporate Compliance Plan are protected and that individuals reporting suspected violations, fraud, or abuse are not retaliated against;
- (f) Require that confirmed violations of the Corporate Compliance Plan be reported to DMH within twenty-four (24) hours of confirmation; and
- (g) Require any confirmed or suspected fraud and abuse under state or federal law or regulation be reported to DMH.

3410.39 Each MHRS provider shall ensure that sufficient resources (e.g. personnel, hardware, software) are available to support the operations of computerized systems for collection, analysis, and reporting of information, along with claims submission.

3410.40 Each MHRS provider shall have the capability to interact with the DMH contract management system as required by DMH.

3410.41 Claims for MHRS shall be submitted using the format required by DMH.

3410.42 Each MHRS provider shall manage information in compliance with the confidentiality requirements contained in applicable federal and District laws and regulations.

3410.43 Each MHRS provider shall establish and adhere to a plan that contains policies and procedures for maintaining the security of data and information (Disaster Recovery Plan). Each MHRS provider's Disaster Recovery Plan shall also stipulate back-up and redundant systems and measures that are designed to prevent the loss of data and information and to enable the recovery of data and information lost due to disastrous events.

3411 **CORE SERVICES AGENCY REQUIREMENTS**

3411.1 Each CSA shall comply with the general certification standards described in §3410, the service specific certification standards applicable to core services and the certification standards set forth in this section, as well as the other certification standards in this Chapter.

3411.2 Each CSA shall:

- (a) Serve as the clinical home for the consumers it enrolls;
- (b) Employ clinical managers, except that a psychiatrist serving as a clinical manager may be under contract to the CSA;

- (c) Be responsible for ensuring that IRPs/PCs are developed and approved for its enrolled consumers; and
- (d) Provide clinical management for its enrolled consumers.

3411.3 Each CSA shall satisfy the following minimum staffing requirements:

- (a) A Chief Executive Officer with professional qualifications and experience who meets the requirements established by the MHRS provider's governing authority. The Chief Executive Officer shall be charged with responsibility for day-to-day management of the CSA, and shall be a full-time employee devoting at least twenty (20) hours a week to administrative and management functions for the CSA;
- (b) A Medical Director who is a board-eligible psychiatrist, responsible for the quality of medical and psychiatric care provided by the MHRS provider. A child and youth-serving CSA may have a staff or consulting board-eligible child psychiatrist or a staff board-eligible psychiatrist with substantial child and adolescent experience as its Medical Director;
- (c) A Clinical Director who is a qualified practitioner with an appropriate, relevant behavioral health advanced degree, with overall responsibility for oversight of the clinical program of the MHRS provider. The Clinical Director may also serve as the Medical Director if the Clinical Director is a board-eligible psychiatrist;
- (d) A full-time Controller, Chief Financial Officer, or designated individual responsible for executing or overseeing the financial operations of the MHRS provider. The designated financial officer shall have a Bachelors Degree plus two (2) years of fiscal experience and may also oversee administrative operations and information services;
- (e) A Quality Improvement Director responsible for developing and implementing the CSA's QI program; and
- (f) A Medical Records Administrator, responsible for:
 - (1) Ongoing quality control of clinical documentation;
 - (2) Assuring that clinical records are maintained, completed, and preserved in accordance with the MHRS provider's Clinical Records Policy;
 - (3) Assuring that information on enrolled consumers is immediately retrievable; and
 - (4) Establishing a central records index for the MHRS provider.

3411.4

Each CSA shall comply with the following requirements regarding clinical operations:

- (a) All consumers receiving treatment from or through a CSA shall choose a clinical manager from the CSA's staff.
- (b) The clinical manager, along with the consumer and the approving practitioner, shall be responsible for the development of the consumer's IRP/IPC and coordinating the delivery of all MHRS received by the consumer.
- (c) The clinical manager shall participate in the development of the IRP/IPC and shall periodically review its effectiveness with the consumer.
- (d) The clinical manager shall be primarily responsible for assuring that the IRP assists the adult consumer in developing self-care skills and achieving recovery, and that the IPC assists the child or youth consumer and family to achieve age-appropriate growth and development.
- (e) Each CSA shall establish and adhere to policies and procedures governing its relationship with sub-providers and specialty providers (Affiliated Provider Policy). The Affiliated Provider Policy shall address, at a minimum, access to records, clinical responsibility, and dispute resolution.
- (f) Each CSA shall establish and adhere to policies and procedures governing its relationship with subcontractors (Subcontractor Policy). The Subcontractor Policy shall address, at a minimum, access to records, clinical responsibility and supervision, legal liability, insurance and dispute resolution.
- (g) Each CSA shall establish and adhere to policies and procedures governing the means by which family education and support will be offered and provided (Consumer and Family Education Policy). The Consumer and Family Education Policy shall require, at a minimum, the following:
 - (1) The CSA shall make family education and support available for all consumer families;
 - (2) Family education and support shall include general information about mental health and psychiatric illness;
 - (3) Specific information about a consumer's situation shall be provided with the permission of the consumer, or in the case of child, with the permission of the parent or guardian in accordance with the CSA's Release of Consumer Information Policy;

- (4) The availability of appointments for family members to meet with staff and availability of family support and education groups to be scheduled at times convenient for the family; and
- (5) In written materials and face-to-face contacts provide information about available and needed services, as well as how the consumer may access Crisis/Emergency services. The materials shall be written at the 4th grade reading level and shall be printed in English and either Spanish or the secondary language conducive to facilitating communication with the majority of the CSA's target population.
- (h) All materials regarding the availability of certified MHRS providers shall be reviewed and approved by DMH.

3411.5 Each CSA shall comply with the following requirements regarding service accessibility:

- (a) Each CSA shall operate an on-call system for its enrolled Consumers twenty-four (24) hours per day, seven (7) days per week, which is staffed by qualified practitioners to respond to urgent, emergency and routine situations (CSA On-Call System).
- (b) Each CSA shall establish and adhere to policies and procedures governing the operation of its On-Call System (On-Call System Policy). The On-Call System Policy shall require the CSA to provide:
 - (1) Direct telephone access to a qualified practitioner for consumers and their significant others to resolve problems telephonically, where possible;
 - (2) Timely access to a qualified practitioner in order to provide any needed face-to-face crisis support services; and
 - (3) Linkage to Crisis/Emergency services, including crisis stabilization services and "next day" appointments to assist the consumer to address urgent problems during the next business day; and
 - (4) Face-to-face response by a qualified practitioner within two (2) hours to the consumer's request for service.
- (c) Each CSA shall, at a minimum, offer the core services as required by §3414, §3415, §3416, §3417 and §3418 of these certification standards.
- (d) Each CSA shall ensure that its business hours comply with the requirements of §3410.20 and facilitate each enrolled consumer's ability to choose an MHRS provider.

- (e) Each potential consumer presenting with an urgent need shall be provided an appointment by a CSA with a qualified practitioner for a face-to-face intervention within the same day that the consumer presents for service.
- (f) Each potential consumer presenting with a routine need shall be provided an intake appointment by a CSA for an intake appointment within seven (7) business days of presentation for service.
- (g) Each CSA shall have policies and procedures for the provision of outreach services, including means by which these services and individuals will be targeted for such efforts (Outreach Policy). The Outreach Policy shall include procedures for protecting the safety of staff who engage in outreach activities.

3411.6 In addition to complying with the requirements set forth in §3410.27, each CSA shall have a QI program directed by a committee comprised of qualified practitioners and staff directly involved in the provision of services (QI Committee). The QI Committee shall:

- (a) Be chaired by a qualified practitioner with direct access to the Chief Executive Officer;
- (b) Include consumers and family members;
- (c) Review unusual incidents, deaths, and other sentinel events, monitor and review utilization patterns, and track consumer complaints and grievances; and
- (d) Conduct an annual evaluation of the QI program, periodically revise the QI program description, and develop the annual QI plan.

3411.7 Each CSA shall make a play area available for children in the waiting room area.

3411.8 Each CSA shall have a full-time Controller, Chief Financial Officer, or a designated individual who is responsible for executing or overseeing the financial operations of the CSA, as described in §3410.29, §3410.33, §3410.34, §3410.35, §3410.36, §3410.37, §3410.40, §3410.41 and §3411.9.

3411.9 Each CSA shall have an annual audit by a certified public accounting firm, and the resulting audit report shall be consistent with formats recommended by the American Institute of Public Accountants. A copy of the most recently certified annual audit report shall be submitted to DMH within one hundred-twenty (120) days after the close of the CSA's fiscal year.

3411.10 Each CSA shall enter into an affiliation agreement with its sub-providers and all specialty providers that specifies the responsibilities of the parties.

- 3411.11 Each CSA shall be responsible for submitting IRP/IPC information to the DMH contract management system in order to register all medically necessary MHRS for its enrolled consumers and for updating and re-submitting the IRP/IPC for each of its enrolled consumers to the DMH contract management system at least every ninety (90) days and as necessary.
- 3411.12 Each CSA shall have the capability to submit timely and accurate claims, encounter data and other submissions as necessary directly to the DMH contract management system.
- 3411.13 DMH shall review and approve each CSA's Affiliated Provider Policy, Subcontractor Policy, Consumer and Family Education Policy, On-Call System Policy and Outreach Policy.
- 3412 SUBPROVIDER AND SPECIALTY PROVIDER REQUIREMENTS**
- 3412.1 Each sub-provider and specialty provider shall comply with the certification standards described in §3410, the service specific standards applicable to the MHRS offered by the sub-provider or specialty provider and the certification standards described in this section, as well as the other certification standards in this Chapter.
- 3412.2 Sub-providers shall provide one (1) or more of the core services only through an affiliation agreement with a CSA.
- 3412.3 Each sub-provider shall establish and adhere to policies and procedures governing its relationship with a CSA which address access to records, clinical responsibility, legal liability, dispute resolution, and all other MHRS certification standards (CSA Affiliation Policy).
- 3412.4 Specialty providers shall provide one (1) or more of the specialty services only through a referral arrangement with a CSA, which is documented in an affiliation agreement.
- 3412.5 Each specialty provider shall establish and adhere to policies and procedures governing its relationship with a CSA which address access to records, clinical responsibilities, legal liability, dispute resolution, and all other MHRS certification standards (CSA Referral Policy).
- 3412.6 Each sub-provider and specialty provider shall satisfy the following minimum staffing requirements:
- (a) A Chief Executive Officer or Program Director with professional qualifications and experience who shall meet requirements as established by the MHRS provider's governing authority and is responsible for day-to-day management of the MHRS provider;

- (b) A Consulting Psychiatrist who is a board-eligible psychiatrist and advises the sub-provider or specialty provider on the quality of medical and psychiatric care provided;
- (c) Each child-serving sub-provider and specialty provider shall demonstrate adequate child and adolescent psychiatric coverage by having a Consulting Psychiatrist who is either a board-eligible child psychiatrist or a board-eligible psychiatrist with substantial child and adolescent experience;
- (d) A Clinical Director who is a qualified practitioner with overall responsibility for oversight of the clinical program of the subprovider or specialty provider;
- (e) Each sub-provider certified to provide either Diagnostic/Assessment or Medication/Somatic Treatment shall demonstrate adequate oversight of quality of medical and psychiatric care by employing or contracting with a Medical Director or arranging for the Medical Director for the consumer's CSA to provide such oversight; and
- (f) The required staff listed above shall be either employees of the sub-provider or specialty provider or under contract to the sub-provider or specialty provider for an amount of time sufficient to carry out the duties assigned.

3412.7 Each sub-provider and specialty provider shall establish and adhere to policies and procedures governing its collaboration with a referring CSA in the development, implementation, evaluation, and revision of each consumer's IRP/IPC and ISSPs, as appropriate, that comply with DMH rules (Collaboration Policy). The Collaboration Policy shall:

- (a) Be part of each sub-provider and specialty provider's Treatment Planning Policy;
- (b) Require sub-providers and specialty providers to incorporate CSA-developed Diagnostic/Assessment material into the sub-provider and specialty provider's treatment planning process; and
- (c) Require sub-providers and specialty providers to coordinate the consumer's treatment with the consumer's clinical manager.

3412.8 Each subprovider shall offer core services as required by §3410.20. At a minimum, the subprovider shall offer services during these hours at its primary location.

3412.9 At a minimum, each specialty provider shall offer access to specialty services as required by §3410.20.

- 3412.10 Each subprovider and specialty provider QI program shall be directed by a coordinator who is a qualified practitioner and who has direct access to the Chief Executive Officer (QI Coordinator). The QI Coordinator shall review unusual incidents, deaths, and other sentinel events, monitor and review utilization patterns, and track consumer complaints and grievances.
- 3412.11 Each subprovider and specialty provider with total annual revenues at or exceeding three hundred thousand dollars (\$300,000) shall have an annual audit by a certified public accounting firm in accordance with generally accepted auditing standards. The resulting financial audit report shall be consistent with formats recommended by the American Institute of Public Accountants. Each subprovider and specialty provider shall submit a copy of the financial audit report to DMH ninety (90) days after the end of its fiscal year.
- 3412.12 Each subprovider and specialty provider with total annual revenues less than three hundred thousand dollars (\$300,000) shall submit financial statements reviewed by an independent certified public accounting firm one hundred twenty (120) days after the end of its fiscal year.
- 3412.13 Each sub-provider shall enter into an affiliation agreement with one (1) or more CSAs that specifies the terms of the arrangement between the parties.
- 3412.14 Each specialty provider shall enter into an affiliation agreement with all CSAs that specifies the terms of the arrangement between the parties.
- 3412.15 Each sub-provider and specialty provider shall have the capability to submit timely and accurate claims, encounter data, and other submissions as necessary directly to the DMH contract management system.
- 3412.16 Each sub-provider and specialty provider shall only provide those MHRS to consumers that are specified in the consumers' IRP/IPC as designated by the consumers' CSA.
- 3412.17 DMH shall review and approve the CSA Affiliation Policy, the CSA Referral Policy and the Collaboration Policy.

3413 QUALIFIED PRACTITIONERS AND CREDENTIALLED STAFF

3413.1 MHRS shall be provided by qualified practitioners either directly or under the supervision of another qualified practitioner as set forth in this chapter. Qualified practitioners are:

- (a) Psychiatrists;
- (b) Psychologists;
- (c) LICSWs;
- (d) APRNs;
- (e) RNs;
- (f) LPC;
- (g) LISWs; and
- (h) Addiction counselors.

3413.2 Only four (4) categories of qualified practitioners shall be authorized to diagnose mental illness for purposes of determining eligibility for MHRS. Those qualified practitioners are:

- (a) Psychiatrists;
- (b) Psychologists;
- (c) LICSWs; and
- (d) APRNs.

3413.3 Qualified practitioners and credentialed staff shall provide MHRS to the extent permitted by and in accordance with District law. Credentialed staff shall be authorized to provide MHRS or components of MHRS under the supervision of an appropriate qualified practitioner in accordance with applicable federal and District law.

3413.4 A psychiatrist shall include a:

- (a) Physician licensed by the District who is, at a minimum a board-eligible psychiatrist;
- (b) Psychiatric resident providing care in an approved clinical rotation; or
- (c) Moonlighting psychiatric resident.

- 3413.5 A psychiatric resident is a medical school graduate from a program that meets the standards for medical education found in 17 DCMR §4602.3, who:
- (a) Has completed at least one year of a psychiatric residency program that satisfies the requirements of 17 DCMR §4611.4;
 - (b) Is currently in a psychiatric residency program that satisfies the requirements of 17 DCMR §4611.5 and is approved by DMH's chief clinical officer as a training program in community psychiatry;
 - (c) Is supervised by a licensed psychiatrist who satisfies the requirements of 17 DCMR §4611.6;
 - (d) Complies with the requirements of 17 DCMR §§4611.7 and 8; and
 - (e) Complies with the standards of conduct for licensed physicians found in 17 DCMR §4612.
- 3413.6 A moonlighting psychiatric resident is a medical school graduate who:
- (a) Satisfies all of the requirements of §3413.4; and
 - (b) Is working under the supervision of the medical director or consulting psychiatrist of a certified MHRS provider in accordance with protocols approved by DMH's chief clinical officer.
- 3413.7 Qualified practitioners are authorized to provide MHRS as described below:
- (a) Psychiatrists are authorized to provide:
 - (1) Diagnostic/Assessment;
 - (2) Medication/Somatic Treatment;
 - (3) Counseling;
 - (4) Community Support
 - (5) Crisis/Emergency;
 - (6) Rehabilitation/Day Services;
 - (7) Intensive Day Treatment;
 - (8) CBI; and
 - (9) ACT;
 - (b) Psychologists are authorized to provide:

- (1) Diagnostic/Assessment;
 - (2) Counseling;
 - (3) Community Support
 - (4) Crisis/Emergency;
 - (5) Rehabilitation/Day Services;
 - (6) Intensive Day Treatment;
 - (7) CBI; and
 - (8) ACT;
- (c) LICSWs are authorized to provide:
- (1) Diagnostic/Assessment;
 - (2) Counseling;
 - (3) Community Support;
 - (4) Crisis/Emergency;
 - (5) Rehabilitation/Day Services;
 - (6) Intensive Day Treatment; and
 - (7) CBI;
- (d) LISWs are authorized to provide:
- (1) Diagnostic/Assessment (assessment only);
 - (2) Counseling;
 - (3) Community Support;
 - (4) Crisis/Emergency;
 - (5) Rehabilitation/Day Services;
 - (6) Intensive Day Treatment; and
 - (7) CBI;
- (e) APRNs are authorized to provide:
- (1) Diagnostic/Assessment;

- (2) Medication/Somatic Treatment;
 - (3) Counseling;
 - (4) Community Support;
 - (5) Crisis/Emergency;
 - (6) Rehabilitation/Day Services;
 - (7) Intensive Day Treatment;
 - (8) CBI; and
 - (9) ACT;
- (f) RNs are authorized to provide:
- (1) Diagnostic/Assessment (assessment only)
 - (2) Medication/Somatic Treatment;
 - (3) Counseling;
 - (4) Community Support;
 - (5) Rehabilitation/Day Services;
 - (6) Intensive Day Treatment;
 - (7) CBI; and
 - (8) ACT;
- (g) LPCs are authorized to provide:
- (1) Diagnostic/Assessment (assessment only);
 - (2) Counseling;
 - (3) Community Support;
 - (4) Rehabilitation/Day Services;
 - (5) Intensive Day Treatment; and
 - (6) CBI;
- (h) Addiction Counselors are authorized to provide:
- (1) Diagnostic/Assesment (assessment only)

- (2) Counseling;
- (3) Community Support;
- (4) Rehabilitation/Day Services;
- (5) Intensive Day Treatment;
- (6) CBI; and
- (7) ACT.

3413.8 The staffing requirements for MHRS are described below.

MHRS	QUALIFIED PRACTITIONERS	QUALIFIED PRACTITIONERS AND CREDENTIALLED STAFF WITH SUPERVISION
Diagnostic/ Assessment	<ul style="list-style-type: none"> • Psychiatrist • Psychologist • LICSW • APRN May diagnose and assess May serve as the approving practitioner	<ul style="list-style-type: none"> • Registered Nurse • LPC • LISW • Addiction Counselor • Credentialed Staff May provide assessment services only.
Medication/ Somatic Treatment	<ul style="list-style-type: none"> • Psychiatrist • APRN • Registered Nurse 	None
Counseling	<ul style="list-style-type: none"> • Psychiatrist • Psychologist • LICSW • APRN • RN • LPC • LISW • Addiction Counselor 	<ul style="list-style-type: none"> • Licensed Graduate Social Worker may provide Counseling under the supervision of an LICSW or an LISW. • Credentialed Staff
Community Support	<ul style="list-style-type: none"> • Psychiatrist • Psychologist • LICSW • APRN • Registered Nurse • LPC • LISW • Addiction Counselor 	Credentialed Staff

MHRS	QUALIFIED PRACTITIONERS	QUALIFIED PRACTITIONERS AND CREDENTIALLED STAFF WITH SUPERVISION
Crisis/ Emergency	<ul style="list-style-type: none"> • Psychiatrist • Psychologist • LICSW • APRN 	<ul style="list-style-type: none"> • Registered Nurse • LPC • LISW • Addiction Counselor • Credentialed Staff
Rehabilitation/Day Services	<ul style="list-style-type: none"> • Psychiatrist • Psychologist • LICSW • APRN • Registered Nurse • LPC • LISW • Addiction Counselor 	Credentialed Staff
Intensive Day Treatment	<ul style="list-style-type: none"> • Psychiatrist • Psychologist • LICSW • APRN • Registered Nurse • LPC • LISW • Addiction Counselor 	Credentialed Staff
CBI	<ul style="list-style-type: none"> • Psychiatrist • Psychologist • LICSW • APRN • Registered Nurse • LPC • LISW • Addiction Counselor 	Credentialed Staff
ACT	<ul style="list-style-type: none"> • Psychiatrist • APRN • RN • Addiction Counselor 	Credentialed Staff

3414 COVERED MHRS

3414.1 The service specific standards described in this section apply to the individual MHRS offered by each MHRS provider and reimbursed by DMH in accordance with this chapter.

3414.2 Covered core services shall include Diagnostic/Assessment, Medication/Somatic Treatment, Counseling, and Community Support.

3414.3 Covered specialty services shall include Crisis/Emergency, Rehabilitation/Day Services, Intensive Day Treatment, CBI, and ACT.

3415 **DIAGNOSTIC/ASSESSMENT**

3415.1 A Diagnostic/Assessment is an intensive clinical and functional evaluation of a consumer's mental health condition by the Diagnostic/Assessment team that results in the issuance of a Diagnostic Assessment report with recommendations for service delivery that provides the basis for the development of an IRP/IPC. A psychiatrist shall supervise and coordinate all psychiatric and medical functions required by a consumer's Diagnostic/Assessment.

3415.2 A Diagnostic/Assessment shall:

- (a) Determine whether the consumer is appropriate for and can benefit from MHRs based upon the consumer's diagnosis, presenting problems, and recovery goals; and
- (b) Evaluate the consumer's level of readiness and motivation to engage in treatment.

3415.3 The Diagnostic/Assessment team shall include the following persons:

- (a) At least two (2) qualified practitioners;
- (b) One (1) of the members shall be a qualified practitioner whose professional licensure authorizes the qualified practitioner to diagnose mental illnesses;
- (c) The approving practitioner who may also be the qualified practitioner authorized to diagnose mental illness; and
- (d) A qualified practitioner who is knowledgeable about community resources, if one of the required Diagnostic/Assessment team members does not possess this knowledge.

3415.4 An initial Diagnostic/Assessment shall be performed by a Diagnostic/Assessment team for each consumer being considered for enrollment with a CSA.

3415.5 The Diagnostic/Assessment shall include the following elements:

- (a) A chronological behavioral health history of the consumer's symptoms, treatment, treatment response, and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;

- (b) For youth and adults, the chronological behavioral health history includes both psychiatric history and substance abuse history, treatment history for either or both diagnoses and the consumer's perception of the outcome;
- (c) Biological, psychological, familial, social, and environmental dimensions and identified strengths and weaknesses in each area;
- (d) A description of the presenting problem(s), including source of distress, precipitating events, associated problems or symptoms, and recent progression;
- (e) Both a strengths summary and a problem summary, which address the following:
 - (1) Risk of harm;
 - (2) Functional status, including relevant emotional and behavioral conditions or complications and addressing self-control, self-care, interpersonal abilities, coping, and independent living skills;
 - (3) Co-morbidity, including biomedical conditions and complications;
 - (4) Recovery environment, including supports and stressors; and
 - (5) Treatment and recovery history, including relapse potential;
- (f) Diagnoses on all five (5) Axes of the DSM-IV;
- (g) A review of the consumer's alcohol and substance abuse history and presenting problem(s), including an assessment of substances used and intensity of use, the likelihood and severity of withdrawal, and the medical and behavioral risk secondary to intoxication. This review either identifies or excludes substance abuse or dependence as a co-occurring treatment need;
- (h) Assessment of the need for psychiatric hospitalization for consumers being referred to psychiatric inpatient services to assure that less restrictive alternatives are considered and used when appropriate;
- (i) Evidence of an interdisciplinary team process; and
- (j) Evidence of consumer participation including, families or guardians where required.

3415.6 The Diagnostic/Assessment may include psychological testing.

- 3415.7 Following the completion of the Diagnostic/Assessment, a summary of findings and recommendations for treatment shall be listed in a Diagnostic/Assessment report. A Diagnostic/Assessment report shall identify barriers to be addressed during treatment in order to reduce or eliminate identified deficits.
- 3415.8 A qualified practitioner shall complete the Diagnostic/Assessment report no later than ten (10) business days after the completion of the Diagnostic/Assessment by the Diagnostic/Assessment team. The qualified practitioner shall provide the Diagnostic/Assessment report to the approving practitioner, and the approving practitioner shall incorporate results of the Diagnostic/Assessment into the IRP/IPC.
- 3415.9 The approving practitioner shall convene the consumer, the consumer's family and significant others, if appropriate, and the consumer's clinical manager to review the Diagnostic/Assessment report and develop the IRP/IPC.
- 3415.10 One Diagnostic/Assessment shall be allowable every six (6) months. Additional units of Diagnostic/Assessment shall be allowable when pre-authorized by DMH for:
- (a) Periodic assessment;
 - (b) Pre-Hospitalization screening;
 - (c) Neuro-psychological assessment; or
 - (d) Re-Admission to Rehabilitation/Day Services.
- 3415.11 Diagnostic/Assessment shall not be billed on the same day as ACT.
- 3415.12 Diagnostic/Assessment services shall be provided:
- (a) At the MHRS provider's service site;
 - (b) In natural settings, including the consumer's home or other community setting; or
 - (c) In a residential facility of sixteen (16) beds or less.
- 3415.13 Qualified practitioners of Diagnostic/Assessment authorized to both diagnose and assess are:
- (a) Psychiatrists;
 - (b) Psychologists;
 - (c) LICSWs; and

(d) APRNs.

3415.14 Qualified practitioners of Diagnostic/Assessment authorized to provide assessment services under the supervision of a qualified practitioner identified in §3415.13 are:

(a) RNs;

(b) LISWs;

(c) LPCs; and

(d) Addiction counselors.

3415.15 Credential staff shall be authorized to provide assessment services under the supervision of a qualified practitioner as set forth in §3413.3.

3416 MEDICATION/SOMATIC TREATMENT

3416.1 Medication/Somatic Treatment services are medical interventions including physical examinations; prescription, supervision or administration of mental-health related medications; monitoring and interpreting results of laboratory diagnostic procedures related to mental health-related medications; and medical interventions needed for effective mental health treatment provided as either an individual or group intervention.

3416.2 Medication/Somatic Treatment services include monitoring the side effects and interactions of medication and the adverse reactions which a consumer may experience, and providing education and direction for symptom and medication self-management.

3416.3 Group Medication/Somatic Treatment services shall be therapeutic, educational and interactive with a strong emphasis on group member selection, facilitated therapeutic peer interaction and support as specified in the IRP/IPC.

3416.4 Each Medication/Somatic Treatment provider shall offer a comprehensive psycho-educational program for consumers and families, as appropriate, regarding the consumer's mental illness, emotional disturbance or behavior disorder, treatment goals, potential benefits and risk of treatment, self-monitoring aids, and consumer/family groups for education, support, and enhancement of the therapeutic alliance between the consumer and the MHRS provider.

3416.5 Consumers receiving Medication/Somatic Treatment shall participate in a psycho-educational session to discuss medication side effects, adverse reactions to medications, and medication self-monitoring and management in conjunction with the following:

(a) Development of the IRP/IPC;

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- (b) Ninety (90) day IRP/IPC review;
- (c) Ninety (90) day ISSP review; and
- (d) Any time the consumer's medications are changed.

3416.6 All consumers receiving Medication/Somatic Treatment services shall be evaluated on the Abnormal Involuntary Movement Scale (AIMS) annually, and the results of the AIMS testing shall be incorporated into the medication assessment and treatment planning process for each consumer receiving Medication/Somatic Treatment.

3416.7 Medication/Somatic Treatment shall be provided with no annual limits on service.

3416.8 Medication/Somatic Treatment shall not be billed on the same day as ACT.

3416.9 Medication/Somatic Treatment shall be provided:

- (a) At the MHRS provider's service site;
- (b) In natural settings, including the consumer's home or other community setting; or
- (c) A residential facility of sixteen (16) beds or less.

3416.10 Qualified practitioners of Medication/Somatic Treatment are:

- (a) Psychiatrists;
- (b) APRNs; and
- (c) RNs.

3417 **COUNSELING**

3417.1 Counseling services are individual, group or family face-to-face services for symptom and behavior management, development, restoration or enhancement of adaptive behaviors and skills, and enhancement or maintenance of daily living skills.

3417.2 Adaptive behaviors and skills and daily living skills include those skills necessary to access community resources and support systems, interpersonal skills, and restoration or enhancement of the family unit and/or support of the family. Mental health supports and consultation services provided to consumers' families are reimbursable only when such services and supports are directed exclusively to the well-being and benefit of the consumer.

3417.3 Counseling services provided in excess of one hundred sixty (160) units require pre-authorization from DMH in accordance with §3404.

3417.4 Counseling shall not be billed on the same day as:

- (a) Rehabilitation/Day Services;
- (b) Intensive Day Treatment;
- (c) CBI; or
- (d) ACT.

3417.5 Counseling services shall be provided:

- (a) At the MHRS provider's service site;
- (b) In natural settings, including the consumer's home or other community setting; or
- (c) A residential facility of sixteen (16) beds or less.

3417.6 Qualified practitioners of Counseling are:

- (a) Psychiatrists;
- (b) Psychologists;
- (c) LICSWs;
- (d) APRNs;
- (e) RNs;
- (f) LPCs;
- (g) LISWs; and
- (h) Addiction counselors.

3417.7 Credentialed staff shall be authorized to provide Counseling services under the supervision of a qualified practitioner as set forth in §3413.3.

3418 **COMMUNITY SUPPORT**

3418.1 Community Support services are rehabilitation and environmental supports considered essential to assist the consumer in achieving rehabilitation and recovery goals that focus on building and maintaining a therapeutic relationship with the consumer.

3418.2 Community Support services include a variety of interventions, such as:

- (a) Participation in the development and implementation of a consumer's IRP/IPC and Community Support ISSP;
- (b) Assistance and support for the consumer in stressor situations;
- (c) Mental health education, support and consultation to consumers' families and their support system, which is directed exclusively to the well-being and benefit of the consumer;
- (d) Individual mental health intervention for the development of interpersonal and community coping skills, including adapting to home, school, and work environments;
- (e) Assisting the consumer in symptom self-monitoring and self-management for the identification and minimization of the negative effects of psychiatric symptoms, which interfere with the consumer's daily living, financial management, personal development, or school or work performance;
- (f) Assistance to the consumer in increasing social support skills and networks that ameliorate life stresses resulting from the consumer's mental illness or emotional disturbance and are necessary to enable and maintain the consumer's independent living;
- (g) Developing strategies and supportive mental health intervention for avoiding out-of-home placement for adults, children, and youth and building stronger family support skills and knowledge of the adult, child, or youth's strengths and limitations; and
- (h) Developing mental health relapse prevention strategies and plans.

3418.3 Community Support services may be provided by a team of staff that is responsible for an assigned group of consumers, or by staff who are individually responsible for assigned consumers.

3418.4 Community Support services provided to children and youth shall include coordination with family and significant others and with other systems of care, such as education managed health plans (including Medicaid managed care plans), juvenile justice, and children's protective services when appropriate to treatment and educational needs.

3418.5 Community Support services shall be provided:

- (a) At the MHRS provider service site;

- (b) In natural settings, including the consumer's home or other community settings; or
- (c) In a residential facility of sixteen (16) beds or less.

3418.6 Each Community Support provider shall have policies and procedures included in its Service Specific Policies addressing the provision of Community Support (Community Support Organizational Plan) which address the following:

- (a) Description of the particular rehabilitation, recovery, and case management models utilized, types of intervention practiced, and typical daily schedule for staff;
- (b) Description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated;
- (c) The use of level of functioning assessments to determine the number of consumers each staff can serve based on DMH guidelines; and
- (d) Description of how the ISSP is modified or adjusted to meet the needs specified in each consumer's IRP/IPC.

3418.7 The Community Support provider shall maintain a staffing ratio of no less than one (1) staff person for every twenty (20) consumers for children and youth, and one (1) staff person for every forty (40) consumers for adults.

3418.8 Community Support services shall be delivered in accordance with the service accessibility requirements in §3410.20.

3418.9 Community Support shall be provided with no annual limits on service.

3418.10 Community Support shall not be billed on the same day as ACT.

3418.11 Qualified practitioners of Community Support are:

- (a) Psychiatrists;
- (b) Psychologists;
- (c) LICSWs;
- (d) APRNs;
- (e) RNs;
- (f) LPCs;
- (g) LISWs; and
- (h) Addiction counselors.

3418.12 Credentialed staff shall be authorized to provide Community Support services under the supervision of a qualified practitioner as set forth in §3413.3.

3419 **CRISIS/EMERGENCY**

3419.1 Crisis/Emergency is a face-to-face or telephone immediate response to an emergency situation involving a consumer with mental illness or emotional disturbance that is available twenty-four (24) hours per day, seven (7) days per week.

3419.2 Crisis/Emergency services are provided to consumers involved in an active mental health crisis and consist of immediate response to evaluate and screen the presenting situation, assist in immediate crisis stabilization and resolution, and ensure the consumer's access to care at the appropriate level.

3419.3 Crisis/Emergency services may be delivered in natural settings, and the Crisis/Emergency provider shall adjust its staffing to meet the requirements for immediate response.

3419.4 Each Crisis/Emergency provider shall:

- (a) Obtain consultation, locate other MHRS and resources, and provide written and oral information to assist the consumer in obtaining follow-up MHRS;
- (b) Be a DMH-certified MHRS provider of Diagnostic/Assessment or have an agreement with a CSA or a CSA's affiliated sub-provider to assure the provision of necessary hospital pre-admission screenings;
- (c) Demonstrate the capacity to assure continuity of care for consumers by facilitating follow-up mental health appointments and providing telephonic support until outpatient services occur; and

- (d) Have an agreement with the DMH Consumer Enrollment and Referral System.
- 3419.5 Each Crisis/Emergency provider shall have waiting, assessment, and treatment areas for children, youth, and families that are separate from the areas for adults.
- 3419.6 Each Crisis/Emergency provider shall establish and adhere to policies and procedures and staffing sufficient to ensure that all individuals seeking and in need of Crisis/Emergency services receive face-to-face services within one (1) hour of request or referral (Crisis/Emergency Staffing Policy). The Crisis/Emergency Staffing Policy shall:
- (a) Require qualified practitioners to be available twenty-four (24) hours per day, seven (7) days per week for telephone, face-to-face and mobile interventions for individuals needing crisis services;
 - (b) Delineate the criteria upon which appropriate venue for service delivery is determined;
 - (c) Require that backup support for staff who need assistance during an intervention is always available;
 - (d) Require that all staff receive current training in persuasion, engagement, and de-escalation techniques for disruptive or aggressive acts, consumers, and situations; and
 - (e) Require all staff to hold current certification in cardiopulmonary resuscitation technique and first aid.
- 3419.7 Crisis/Emergency shall be provided with no annual limits on services.
- 3419.8 Retrospective authorization from DMH is required for Crisis/Emergency services provided on the same day as ACT.
- 3419.9 Crisis/Emergency services shall be provided:
- (a) At the MHRS provider service site; or
 - (b) In natural settings, including the consumer's home or other community settings.
- 3419.10 Qualified practitioners of Crisis/Emergency are:
- (a) Psychiatrists;
 - (b) Psychologists;
 - (c) LICSWs;

(d) LISWs; and

(e) APRNs.

3419.11 Qualified practitioners authorized to provide Crisis/Emergency under the supervision of a qualified practitioner identified in §3419.10 are:

(a) LISWs;

(b) LPCs;

(c) RNs; and

(d) Addiction counselors.

3419.12 Credentialed staff shall be authorized to provide Crisis/Emergency services under the supervision of a qualified practitioner as set forth in §3413.3.

3420 **REHABILITATION/DAY SERVICES**

3420.1 Rehabilitation/Day Services is a structured, clinical program intended to develop skills and foster social role integration through a range of social, psycho-educational, behavioral, and cognitive mental health interventions.
Rehabilitation/Day Services:

(a) Are curriculum-driven and psycho-educational and assist the consumer in the retention, or restoration of independent and community living, socialization, and adaptive skills;

(b) Include cognitive-behavioral interventions and diagnostic, psychiatric, rehabilitative, psychosocial, counseling, and adjunctive treatment; and

(c) Are offered most often in group settings, and may be provided individually.

3420.2 Rehabilitation/Day Services shall:

(a) Be founded on the principles of consumer choice and the active involvement of each consumer in the consumer's mental health recovery;

(b) Provide both formal and informal structures through which consumers can influence and shape service development;

(c) Facilitate the development of a consumer's independent living and social skills, including the ability to make decisions regarding self care, management of illness, life work, and community participation;

- (d) Promote the use of resources to integrate the consumer into the community; and
 - (e) Include education on self-management of symptoms, medications and side effects, the identification of rehabilitation preferences, the setting of rehabilitation goals, and skills teaching and development.
- 3420.3 Each consumer shall choose a full-time staff member to assist the consumer in assessing the consumer's needs and progress toward achievement of Rehabilitation/Day Services Treatment Goals.
- 3420.4 Each Rehabilitation/Day Services provider shall provide adequate space, equipment, and supplies to ensure that services can be provided effectively. Rehabilitation/Day Services program space and furnishings shall be separate and distinct from other services offered within the same service site(s).
- 3420.5 Each Rehabilitation/Day Services provider shall have policies and procedures included in its Service Specific Policies addressing the provision of Rehabilitation/Day Services (Rehabilitation/Day Services Organizational Plan) which include:
- (a) A description of the particular rehabilitation models utilized, types of intervention practiced, and typical daily curriculum and schedule;
 - (b) A description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated; and
 - (c) A description of how the ISSP is modified or adjusted to meet the needs specified in each consumer's IRP/IPC.
- 3420.6 Each Rehabilitation/Day Services provider shall have a minimum of one (1) full-time equivalent staff for every ten (10) consumers, based on average daily attendance.
- 3420.7 At least one (1) qualified practitioner shall be present on site at all times.
- 3420.8 Each Rehabilitation/Day Services provider shall have a clinical supervisor or director who is a qualified practitioner on site at least thirty (30) hours per week.
- 3420.9 Each consumer shall participate in at least three (3) hours of Rehabilitation/Day Services per day, in order for the services to be reimbursable.
- 3420.10 Rehabilitation/Day Services in excess of ninety (90) days within a twelve (12) month period shall require pre-authorization from DMH in accordance with §3404.
- 3420.11 Rehabilitation/Day Services shall not be billed on the same day as ACT.

3420.12 Rehabilitation/Day Services shall only be provided at an MHRS provider's service site.

3420.13 Qualified practitioners of Rehabilitation/Day Services are:

- (a) Psychiatrists;
- (b) Psychologists;
- (c) LICSWs;
- (d) APRNs;
- (e) RNs;
- (f) LPCs;
- (g) LISWs; and
- (h) Addiction counselors.

3420.14 Credentialed staff shall be authorized to provide Rehabilitation/Day Services under the supervision of a qualified practitioner as set forth in §3413.3.

3421 INTENSIVE DAY TREATMENT

3421.1 Intensive Day Treatment is a facility-based, structured, intensive, and coordinated acute treatment program which serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care, rendered by an interdisciplinary team to provide stabilization of psychiatric impairments.

3421.2 Daily physician and nursing services are essential components of Intensive Day Treatment services.

3421.3 Intensive Day Treatment shall:

- (a) Be time-limited and provided in an ambulatory setting to consumers who are not in danger but have behavioral health issues that are incapacitating and interfering with their ability to carry out daily activities;
- (b) Be provided within a structured program of care which offers individualized, strengths-based, active, and timely treatment directed toward the alleviation of the impairment which caused the admission to Intensive Day Treatment;
- (c) Be an active treatment program that consists of documented mental health interventions that address the individualized needs of the consumer as identified in the IRP/IPC;

- (d) Consist of structured individual and group activities and therapies that are planned and goal-oriented and provided under active psychiatric supervision;
 - (e) Offer short-term day-programming consisting of therapeutically intensive, acute, and active treatment;
 - (f) Be services that closely resemble the intensity and comprehensiveness of inpatient services; and
 - (g) Include psychiatric, medical, nursing, social work, occupational therapy, Medication/Somatic Treatment, and psychology services focusing on timely crisis intervention and psychiatric stabilization so that consumers can return to their normal daily lives.
- 3421.4 Each consumer shall participate in at least five (5) hours of Intensive Day Treatment per day, in order for the services to be reimbursable.
- 3421.5 Each consumer shall be directly evaluated by a qualified practitioner as part of the admissions process.
- 3421.6 Each consumer's care shall be supervised by a qualified practitioner who assumes primary responsibility for the consumer's assessment, treatment planning, and treatment services.
- 3421.7 Each consumer shall be assigned to a full-time staff member who assists the consumer and the consumer's family to assess the consumer's needs and progress toward achievement of Treatment Goals.
- 3421.8 An interdisciplinary treatment team shall meet within one (1) working day of the consumer's admission to develop an initial Intensive Day Treatment ISSP.
- 3421.9 Each Intensive Day Treatment ISSP shall be updated every three (3) days and shall be reviewed by the interdisciplinary treatment team on a weekly basis and upon termination of treatment.
- 3421.10 All Intensive Day Treatment services shall occur under the supervision of a psychiatrist. A psychiatrist shall assess each consumer on a daily basis.
- 3421.11 Each Intensive Day Treatment provider shall have policies and procedures included in its Service Specific Policies addressing the provision of Intensive Day Treatment (Intensive Day Treatment Organizational Plan) which include the following:
- (a) A description of the particular treatment models utilized, types of intervention practiced, and typical daily curriculum and schedule;

- (b) A description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated; and
 - (c) A description of how the ISSP is modified or adjusted to meet the needs specified in each consumer's IRP/IPC.
- 3421.12 The Intensive Day Treatment provider shall maintain a minimum staffing ratio of one (1) staff for every eight (8) consumers. The Intensive Day Treatment provider shall maintain a minimum staffing pattern sufficient to address consumer needs, including adequate physician, nursing, social work, therapy, and psychology services to assure the availability of intensive services.
- 3421.13 Intensive Day Treatment units in excess of seven (7) units within a twelve (12) month period shall require pre-authorization from DMH.
- 3421.14 Intensive Day Treatment shall not be billed on the same day as any other MHRS except for Community support, Crisis/Emergency or CBI.
- 3421.15 Intensive Day Treatment shall only be provided in an MHRS provider service site.
- 3421.16 Qualified practitioners of Intensive Day Treatment are:
 - (a) Psychiatrists;
 - (b) Psychologists;
 - (c) LICSWs;
 - (d) APRNs;
 - (e) RNs;
 - (f) LPCs;
 - (g) LISWs; and
 - (h) Addiction counselors.
- 3421.17 Credentialed staff shall be authorized to provide Intensive Day Treatment under the supervision of a qualified practitioner as set forth in §3413.3.
- 3422 **COMMUNITY-BASED INTERVENTION**
- 3422.1 CBI services are time-limited, intensive, mental health services delivered to children, youth, and adults and intended to prevent the utilization of an out-of-home therapeutic resource by the consumer.

- 3422.2 The basic goals of CBI services are to:
- (a) Diffuse the current situation to reduce the likelihood of a recurrence, which, if not addressed, could result in the use of more intensive therapeutic interventions;
 - (b) Coordinate access to covered mental health services; and
 - (c) Provide mental health services and support interventions for consumers that develop and improve the ability of parents, legal guardians, or significant others to care for the consumer with mental illness or emotional disturbance.
- 3422.3 CBI services shall be multi-faceted in nature and include:
- (a) Situation management;
 - (b) Environmental assessment;
 - (c) Interventions to improve consumer and family interaction;
 - (d) Skills training;
 - (e) Self and family management; and
 - (f) Coordination and linkage with other covered MHRS and supports and other covered Medicaid services in order to prevent the utilization of more restrictive residential treatment.
- 3422.4 CBI services shall be delivered primarily in natural settings and shall include in-home services. In-home services include:
- (a) Consultation to the consumer, parents, or other caregivers regarding medications, behavior management skills;(b)Dealing with the responses of the consumer, other caregivers, and family members; and
 - (c) Coordinating with other treatment providers, including support and consultation with the consumer's family and/or support system, which is directed exclusively to the well-being and benefit of the consumer.
- 3422.5 CBI services shall be individually designed for each consumer and family to minimize intrusion and maximize independence.
- 3422.6 CBI services are normally more intensive at the beginning of treatment and decrease over time as the consumer or family's strengths and coping skills develop.

- 3422.7 CBI shall be provided through a team approach, utilizing flexible services, with the capacity to address concrete therapeutic and environmental issues in order to stabilize a situation as soon as possible.
- 3422.8 CBI services for children and youth shall always have a family-focus.
- 3422.9 Each CBI provider shall have policies and procedures included in its Service Specific Policies that address the provision of CBI (CBI Organizational Plan) which include the following:
- (a) A description of the particular treatment models utilized, types of intervention practiced, and typical daily curriculum and schedule;
 - (b) A description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated; and
 - (c) A description of how the ISSP is modified or adjusted to meet the needs specified in each consumer's IRP/IPC.
- 3422.10 At a minimum, the CBI team shall include the following members:
- (a) A full-time team leader or supervisor who is the clinical and administrative supervisor of the CBI team and who is a qualified practitioner;
 - (b) An addiction counselor working on a full-time basis and providing or accessing substance abuse services for CBI team consumers who functions as a primary practitioner on the CBI team for a caseload of consumers;
 - (c) A clinically trained generalist practitioner working on a full-time basis and providing individual and group supportive therapy to CBI team consumers who functions as a primary practitioner on the CBI team for a caseload of consumers and is a qualified practitioner; and
 - (d) Recovery specialists carrying out rehabilitation and support functions who may be consumers in recovery that have been specially credentialed based on their psychiatric and life experiences. Recovery specialists are fully integrated CBI team members who provide consultation to the CBI team, highly individualized services in the community, and who promote consumer self-determination and decision making.
- 3422.11 The CBI team shall maintain a minimum consumer-to-staff ratio of no more than four (4) families per staff person, and such ratio shall take into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.

- 3422.12 Pre-authorization from DMH is required prior to enrollment in CBI.
- 3422.13 CBI shall not be billed on the same day as Counseling, Intensive Day Treatment or ACT.
- 3422.14 CBI shall be provided in:
- (a) MHRS provider service sites; or
 - (b) Natural settings, including the consumer's home or other community setting.
- 3422.15 Qualified practitioners of CBI are:
- (a) Psychiatrists;
 - (b) Psychologists;
 - (c) LICSWs;
 - (d) APRNs;
 - (e) RNs;
 - (f) LPCs;
 - (g) LISWs; and
 - (h) Addiction counselors.
- 3422.16 Credentialed staff shall be authorized to provide CBI under the supervision of a qualified practitioner as set forth in §3413.3.
- 3423 **ASSERTIVE COMMUNITY TREATMENT**
- 3423.1 ACT is an intensive, integrated, rehabilitative, crisis, treatment, and mental health rehabilitative community support service provided by an interdisciplinary team to children and youth with serious emotional disturbance and to adults with serious and persistent mental illness with dedicated staff time and specific staff to consumer ratios.
- 3423.2 Service coverage by the ACT team is required twenty-four (24) hours per day, seven (7) days per week.
- 3423.3 The consumer's ACT team shall complete a comprehensive or supplemental assessment and develop a self care-oriented ISSP (if a current and effective one does not already exist).

- 3423.4 Services offered by the ACT team shall include:
- (a) Mental health-related medication prescription, administration, and monitoring;
 - (b) Crisis assessment and intervention;
 - (c) Symptom assessment, management, and individual supportive therapy;
 - (d) Substance abuse treatment for consumers with a co-occurring addictive disorder;
 - (e) Psychosocial rehabilitation and skill development;
 - (f) Interpersonal, social, and interpersonal skill training; and
 - (g) Education, support, and consultation to consumers' families and their support system which is directed exclusively to the well-being and benefit of the consumer.
- 3423.5 ACT services shall include a comprehensive and integrated set of medical and psychosocial services for the treatment of the consumer's mental health condition that is provided in non-office settings by the consumer's ACT team.
- 3423.6 The ACT team provides community support services that are interwoven with treatment and rehabilitative services and regularly scheduled team meetings. ACT team meetings shall be held a minimum of three (3) times a week.
- 3423.7 ACT services and interventions shall be highly individualized and tailored to the needs and preferences of the consumer, with the goal of maximizing independence and supporting recovery.
- 3423.8 Each ACT provider shall have policies and procedures included in its Service Specific Policies that address the provision of ACT (ACT Organizational Plan) which include the following:
- (a) A description of the particular treatment models utilized, types of intervention practice, and typical daily curriculum and schedule;
 - (b) A description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated; and
 - (c) A description of how the ISSP is modified or adjusted to meet the needs specified in each consumer's IRP/IPC.

- 3423.9 At a minimum, the ACT team shall include the following members:
- (a) A full-time team leader or supervisor who is the clinical and administrative supervisor of the ACT team and who is a qualified practitioner;
 - (b) A psychiatrist working on a full-time or part-time basis for a minimum of four (4) hours per week per twenty (20) consumers that provides clinical and crisis services to all consumers served by the ACT team, works with the ACT team leader to monitor each consumer's clinical status and response to treatment, and directs psychopharmacologic and medical treatment;
 - (c) A registered nurse working on a full-time basis and providing nursing services for all ACT team consumers who works with the ACT team to monitor each consumer's clinical status and response to treatment and functions as a primary practitioner on the ACT team for a caseload of consumers;
 - (d) An addiction counselor working on a full-time basis and providing or accessing substance abuse services for ACT team consumers who functions as a primary practitioner on the ACT team for a caseload of consumers;
 - (e) A clinically trained generalist practitioner working on a full-time basis and providing individual and group supportive therapy to ACT team consumers who functions as a primary practitioner on the ACT team for a caseload of consumers and is a qualified practitioner; and
 - (f) Recovery specialists carrying out rehabilitation and support functions who may be consumers in recovery that have been specially credentialed based on their psychiatric and life experiences. Recovery specialists are fully integrated ACT team members who provide consultation to the ACT team, highly individualized services in the community, and who promote consumer self-determination and decision making.
- 3423.10 The ACT team shall maintain a minimum consumer-to-staff ratio of no more than twelve (12) consumers per staff person, and such ratio shall take into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.
- 3423.11 Pre-authorization from DMH is required prior to enrollment for ACT.
- 3423.12 ACT shall not be billed on the same day as any other MHRS except for Crisis/Emergency.
- 3423.13 ACT shall be provided in:

- (a) The MHRS provider's service site; or
- (b) The consumer's home or other community setting.

3423.14 Qualified practitioners of ACT are:

- (a) Psychiatrists;
- (b) Advance Practice Registered Nurses;
- (c) RNs; and
- (d) Addiction counselors.

3423.15 Credentialed staff shall be authorized to provide ACT under the supervision of a qualified practitioner as set forth in §3413.3.

3424 REIMBURSABLE SERVICES

3424.1 Reimbursement for the provision of MHRS shall be on a per unit basis as indicated in §3424.4.

3424.2 Each covered service shall have a unique billing code as established by DMH.

3424.3 Units of service reported for part of an hour shall be rounded to the nearest fifteen minute unit.

3424.4

Reimbursement shall be limited as follows:

MHRS	LIMITATIONS AND SERVICE SETTING	BILLABLE UNIT OF SERVICE
Diagnostic/ Assessment	<ul style="list-style-type: none"> One (1) every six (6) months Additional units allowable when pre-authorized for periodic assessment, pre-hospitalization screening, neuropsychological assessment and re-admission to Rehabilitation/Day Services Shall not be billed the same day as ACT Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less 	An assessment, which is at least three (3) hours in duration
Medication/ Somatic Treatment	<ul style="list-style-type: none"> No annual limit Shall not be billed the same day as ACT Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less 	Fifteen (15) minutes
Counseling	<ul style="list-style-type: none"> One hundred sixty (160) units per year Additional units allowable with prior authorization by DMH Shall not be billed the same day as Rehabilitation/Day Services, Intensive Day Treatment, CBI or ACT Shall be rendered face-to-face, when consumer is present, unless there is adequate documentation to justify why the consumer was not present during the session May be provided in individual on-site, individual off-site or group Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less 	Fifteen (15) minutes
Community Support	<ul style="list-style-type: none"> No annual limits Shall not be billed on the same day as ACT May be provided individually or in a group Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less 	Fifteen (15) minutes
Crisis/ Emergency	<ul style="list-style-type: none"> No annual limits Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less 	Fifteen (15) minutes
Rehabilitatio n/Day Services	<ul style="list-style-type: none"> Ninety (90) days within a twelve (12) month period Additional units allowable with prior authorization by DMH 	One (1) day (which shall consist of at least three (3))

	<ul style="list-style-type: none"> • Shall not be billed on the same day as Counseling or ACT • Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less 	hours)
Intensive Day Treatment	<ul style="list-style-type: none"> • Seven (7) days • Additional units allowable after seven (7) days or for the second and any additional episodes of care within a twelve (12) month period with prior authorization by DMH • Shall not be billed on the same day as any other MHRS, except for Crisis/Emergency, Community Support and CBI. • Up to three (3) hours of Diagnostic/Assessment may be billed during each episode of Intensive Day Treatment • Provided only in a community-based MHRS provider -- Intensive Day Treatment Facility 	One (1) day (which shall consist of at least five (5) hours)
CBI	<ul style="list-style-type: none"> • Prior authorization from DMH required for enrollment • Shall not be billed on the same day as ACT, Counseling or Intensive Day Treatment • Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less 	One (1) hour (or part thereof)
Assertive Community Treatment	<ul style="list-style-type: none"> • Prior authorization from DMH required for enrollment • Shall not be billed on the same day as any other MHRS, except for Crisis/Emergency with retrospective authorization 	One (1) hour (or part thereof)

3425 NON-REIMBURSABLE SERVICES

3425.1 Services not covered as MHRS include, but are not limited to:

- (a) Room and board residential costs;
- (b) Inpatient hospital services, including hospital, nursing facility, intermediate care facility for the mentally retarded and institutions for mental diseases;
- (c) Transportation services;
- (d) Vocational services;
- (e) School and educational services;
- (f) Services rendered by parents or other family members;

- (g) Socialization services;
- (h) Screening and prevention services (other than those provided under Early and Periodic Screening, Diagnosis and Treatment requirements);
- (i) Services which are not medically necessary as recommended in an approved IRP/IPC;
- (j) Services which are not provided and documented in accordance with these certification standards;
- (k) Services which are not mental health services; and
- (l) Services furnished to persons other than the consumer when those services are not directed primarily to the well-being and benefit of the consumer.

3499 **DEFINITIONS**

3499.1 The following terms have the meaning ascribed in this section:

“Addiction counselor” - a person who provides addiction counseling services to persons with co-occurring psychiatric and addictive disorders and is licensed or certified in accordance with applicable District laws and regulations. An addiction counselor is a qualified practitioner.

“Advance Practice Registered Nurse” or “APRN” - a person licensed as an advance practice registered nurse in accordance with applicable District laws and regulations, with psychiatry as an area of practice and working in a collaborative protocol with a psychiatrist. An Advance Practice Registered Nurse is a qualified practitioner.

“Affiliation agreement” - an agreement in the form approved by DMH by and between a CSA and a specialty provider or sub-provider that describes how they will work together to benefit consumers.

“Approving practitioner” - the qualified practitioner responsible for overseeing the development of and approval of the Individual Recovery Plan or Individual Plan of Care (“IRP/IPC”). The approving practitioner serves on the Diagnostic/Assessment team and may also serve as the clinical manager.

“Assertive Community Treatment” or “ACT” - intensive, integrated rehabilitative, crisis, treatment, and mental health rehabilitative community support provided by an interdisciplinary team to children and youth with serious emotional disturbance and to adults with serious and persistent mental illness by an interdisciplinary team. ACT is provided with dedicated staff time and specific staff to consumer ratios. Service coverage by the ACT team is required twenty-four (24) hours per day, seven (7) days per week. ACT is a specialty service.

“Assertive Community Treatment team” or “ACT team” - the mobile interdisciplinary team of qualified practitioners and other staff involved in providing ACT to a consumer.

“CBI team” – The interdisciplinary team of qualified practitioners and other staff involved in providing CBI to a consumer.

“CMS” - Centers for Medicare and Medicaid services, formerly known as the Health Care Financing Agency.

“Certification” - the written authorization from DMH rendering an entity eligible to provide MHRS. DMH grants certification to community-based organizations that submit an approved certification application and satisfy the certification standards.

“Certification application” - the application and supporting materials prepared and submitted to DMH by a community-based organization requesting certification to provide MHRS.

“Certification standards” - the minimum requirements established by DMH in this Chapter that an MHRS provider shall satisfy to obtain and maintain certification to provide MHRS and receive reimbursement from DMH for MHRS.

“Clinical manager” - the qualified practitioner chosen by the consumer to coordinate service delivery. The clinical manager shall participate in the development and review of the consumer’s IRP/IPC, along with the approving practitioner. The clinical manager may also serve as the approving practitioner. The clinical manager shall be employed by the CSA, except that a psychiatrist serving as a clinical manager may be under contract to the CSA.

“Community-Based Intervention” or “CBI” - time-limited, intensive, mental health intervention services delivered to children, youth, or adults and intended to prevent utilization of an out-of-home therapeutic resource by the consumer. CBI is primarily focused on the development of consumer skills and is delivered in the family setting in order for the consumer to function in a family environment. CBI is a specialty service.

“Community Support” - rehabilitation and environmental support considered essential to assist a consumer in achieving rehabilitation and recovery goals. Community support services focus on building and maintaining a therapeutic relationship with the consumer. Community Support is a core service.

“Consumer” – a person eligible to receive MHRS as defined in the District of Columbia Department of Mental Health Establishment Congressional Review Emergency Amendment Act of 2001, effective July 23, 2001 (D.C. Act 14-101).

“Core services” includes the following four categories of MHRS: Diagnostic/Assessment, Medication/Somatic Treatment, Counseling and Psychotherapy, and Community Support.

“Core Services Agency” or “CSA” - a DMH-certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS. A CSA shall provide at least one core service directly and may provide up to three core services via contract with a sub-provider or subcontractor. A CSA may provide specialty services directly if certified by DMH as a specialty provider. However, a CSA shall also offer specialty services via an affiliation agreement with all specialty providers.

“Corporate Compliance Plan” - a written plan developed by each MHRS provider to ensure that the MHRS provider operates in compliance with all applicable federal and District laws and regulations.

“Corrective Action Plan” or “CAP” - a written plan prepared by either an applicant for certification or a DMH-certified MHRS provider describing the actions that the provider intends to take to correct or abate the violations described in a CMP issued by DMH.

“Corrective Measures Plan” or “CMP” - a written statement of non-compliance issued by DMH, which describes the areas in which an applicant for certification or a DMH-certified MHRS provider fails to comply with the certification standards.

“Counseling” - individual, group, or family face-to-face services for symptom and behavior management, development, restoration, or enhancement of adaptive behaviors and skills, and enhancement or maintenance of daily living skills. Mental health supports and consultation services provided to consumer’s families are reimbursable only when such services and supports are directed exclusively to the well-being and benefit of the consumer. Counseling is a core service.

“Credentialed staff” - unlicensed staff or staff who are not qualified practitioners that are credentialed by the MHRS provider to perform certain MHRS or components of MHRS under the clinical supervision of a qualified practitioner.

“Crisis/Emergency” - face-to-face or telephone immediate response to an emergency situation involving a consumer with mental illness or emotional disturbance that is available twenty-four (24) hours per day, seven (7) days per week. Crisis/Emergency services are provided to consumers involved in active mental health crisis and consist of immediate response to evaluate and screen the presenting mental health situation, assist in immediate crisis stabilization and resolution and ensure the consumer’s access to mental health care at the appropriate level. Crisis/Emergency is a specialty service.

“Crisis support services” - mental health services that support the consumer through a crisis, such as meeting with the consumer in the community or an emergency department to help calm the consumer; implementing the crisis plan developed for the consumer; assisting the consumer to reach an emergency department; and providing pertinent mental health information about a consumer to an emergency department to assist in addressing a crisis.

“Cultural competence” - means the ability of a MHRS provider to deliver mental health services and mental health supports in a manner that effectively responds to the languages, values, and practices present in the various cultures of the MHRS provider’s consumers.

“Diagnostic/Assessment” - intensive clinical and functional evaluation of a consumer’s mental health condition that results in the issuance of a Diagnostic/Assessment report with recommendations for service delivery and may provide the basis for the development of the IRP/IPC. A Diagnostic/Assessment shall determine whether the consumer is appropriate for and can benefit from MHRS, based upon the consumer’s diagnosis, presenting problems and recovery goals. Diagnostic/Assessment is a core service.

“Diagnostic/Assessment report” - the report prepared by the Diagnostic/Assessment team that summarizes the results of the Diagnostic/Assessment service and includes recommendations for service delivery. The Diagnostic/Assessment report is used to initiate the IRP/IPC and, if necessary, the ISSP.

“Diagnostic/Assessment team” - at least two (2) qualified practitioners working together to complete the Diagnostic/Assessment and issue the Diagnostic/Assessment report.

“Director” - the director of DMH.

“Disaster Recovery Plan” - the policies and procedures developed by each MHRS provider to ensure that computerized data is properly maintained and can be retrieved in the event of a disaster.

“District of Columbia” or “District” – the government of the District of Columbia.

“District of Columbia State Medicaid Plan” - the plan approved by CMS that is developed and administered by MAA, pursuant to Section 1(b) of An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program and for other purposes and Title XIX of the Social Security Act as added July 30, 1965 (79 Stat. 343; 42 U.S.C. §1396a et seq.), as amended. The program operated in accordance with the District of Columbia State Medicaid Plan is referred to as the “Medicaid” or “Medical Assistance” program.

“DMH” - the Department of Mental Health, the successor in interest to the District of Columbia Commission on Mental Health Services.

“DMH Consumer Enrollment and Referral System” - the system developed and administered by DMH to enroll eligible consumers into the MHRS system.

“DSM IV” - the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

“Emergency” - a situation in which a consumer is experiencing a mental health crisis and the immediate provision of mental health treatment is, in the written judgment of the consumer’s attending physician, necessary to prevent serious injury to the consumer or others.

“Governing authority” - the designated individuals or governing body legally responsible for conducting the affairs of the MHRS provider.

“Grievance” - a description by any individual of his or her dissatisfaction with an MHRS provider, including the denial or abuse of any consumer right or protection provided by applicable federal and District laws and regulations.

“Human Care Agreement” - the written agreement entered into by the DMH-certified MHRS provider and DMH which describes how the parties will work together.

“ICD-9CM” - the most recent version of the International Classification of Diseases Code Manual.

“Independent clinical social worker” or “LICSW” - a person licensed as an independent clinical social worker in accordance with applicable District laws and regulations. An LICSW is a qualified practitioner.

“Individualized Plan of Care” or “IPC” - the individualized plan of care for children and youth, which is the result of the Diagnostic/Assessment. The IPC is maintained by the consumer’s CSA. The IPC includes the consumer’s treatment goals, strengths, challenges, objectives, and interventions. The IPC is based on the consumer’s identified needs as reflected by the Diagnostic/Assessment, the consumer’s expressed needs, and referral information. The IPC shall include a statement of the specific, individualized objectives of each intervention, a description of the interventions, and specify the frequency, duration, and scope of each intervention activity. The IPC also includes the ISSP developed by subproviders and specialty providers involved in providing services to the consumer. The IPC is the authorization of treatment, based on certification that the MHRS are medically necessary by the approving practitioner.

“Individualized Recovery Plan” or “IRP” - an individualized recovery plan for adult consumers, which is the result of the Diagnostic/Assessment. The IRP is maintained by the consumer’s CSA. The IRP includes the consumer’s treatment goals, strengths, challenges, objectives, and interventions. The IRP is based on the consumer’s identified needs as reflected by the Diagnostic/Assessment, the consumer’s expressed needs, and referral information. The IRP shall include a statement of the specific, individualized objectives of each intervention, a description of the interventions, and specify the frequency, duration, and scope of each intervention activity. The IRP also includes the ISSP developed by subproviders and Specialty providers involved in providing services to the consumer. The IRP is the authorization of treatment, based upon certification that MHRS are medically necessary by an approving practitioner.

"Individualized Service Specific Plan" or "ISSP" - the individualized service specific plan developed by an MHRS provider providing Medication/Somatic Treatment, Counseling and Psychotherapy, Community Support, Rehabilitation, Intensive Day Treatment, CBI, or ACT. The ISSP shall be consistent with the IRP/IPC and specify the qualified practitioner designated to deliver the MHRS, and the frequency, duration, and scope of the MHRS.

"Inpatient mental health service" - residence and treatment provided in a psychiatric hospital or unit licensed or operated by the District of Columbia.

"Intensive Day Treatment" - a structured, intensive, and coordinated acute treatment program that serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care, rendered by an inter-disciplinary team to provide stabilization of psychiatric impairments. Its duration is time-limited. Intensive Day Treatment is provided in an ambulatory setting. Intensive Day Treatment is a specialty service.

"Licensed independent social worker" or "LISW" - a person licensed as a licensed independent social worker in accordance with applicable District laws and regulations. An LISW is a qualified practitioner.

"Licensed professional counselor" or "LPC" - a professional counselor licensed in accordance with applicable District laws and regulations. An LPC is a qualified practitioner.

"MAA" - the Department of Health, Medical Assistance Administration.

"MAA/DMH Interagency Agreement" - a written agreement entered into by MAA and DMH which describes how MAA and DMH will handle the operation and administration of the MHRS program.

"Medicaid or Medical Assistance" - the program described in the District of Columbia State Medicaid Plan, approved by CMS, and administered by MAA pursuant to Section 1(b) of An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program and for other purposes and Title XIX of the Social Security Act, as amended July 30, 1965 (79 Stat. 343; 42 U.S.C. § 1396a et seq.).

"Medically necessary" - those services contained in an approved IRP/IPC reasonably calculated to prevent the worsening of, alleviate, correct, cure, or ameliorate an identified mental health condition that endangers life, causes suffering or pain, causes physical deformity or bodily malfunction, threatens to cause or aggravate a disability, or results in an illness or infirmity. For children through age twenty (20), services reasonably calculated to promote the development or maintenance of age-appropriate functioning are also considered medically necessary.

"Medication/Somatic Treatment" - medical interventions, including physical examinations, prescription, supervision or administration of mental-health related

medications, monitoring and interpreting the results of laboratory diagnostic procedures related to mental health-related medications, and medical interventions needed for effective mental health treatment provided as either an individual or group intervention. Medication/Somatic Treatment is a core service.

“Mental Health Rehabilitation Services” or “MHRS” - mental health rehabilitative or palliative services provided by a DMH-certified community mental health provider to consumers in accordance with the District of Columbia State Medicaid Plan, the MAA/DMH Interagency Agreement, and this chapter.

“Mental illness” - a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

“MHRS provider” - an organization certified by DMH to provide MHRS. MHRS provider includes CSAs, sub-providers, and specialty providers.

“Natural settings” - the consumer’s residence, workplace, or other locations in the community the consumer frequents, such as the consumer’s home, school, workplace, community centers, homeless shelters, street locations, or other public facilities. Natural settings do not include inpatient hospitals or community residential facilities.

“Neglect” - any act or omission by a MHRS provider which causes or is likely to cause or contribute to, or which caused or is likely to have caused or contributed to, injury or death of a consumer.

“Policy” - a written statement developed by an MHRS provider that gives specific direction regarding how the MHRS provider shall operate administratively and programmatically.

“Procedure” - a written set of instructions describing the step-by-step actions to be taken by MHRS provider staff in implementing a policy of the MHRS provider.

“Psychiatrist” - a physician licensed in accordance with applicable District laws and regulations who has completed a residency program in psychiatry accredited by the Residency Review Committee for Psychiatry of the Accreditation Council for Graduate Medical Education and is eligible to sit for the psychiatric board examination. A Psychiatrist is a qualified practitioner.

“Psychologist” - a person licensed to practice psychology in accordance with applicable District laws and regulations. A Psychologist is a qualified practitioner.

“Qualified practitioner” - (i) a psychiatrist; (ii) a psychologist; (iii) an independent clinical social worker; (iv) an advance practice registered nurse; (v) a registered nurse; (vi) a licensed professional counselor; (vii) an independent social worker; and (viii) an addiction counselor.

“Referral” - a recommendation to seek or request services or evaluation between a CSA and a sub-provider or specialty provider in order to assess or meet the needs of consumers.

“Registered nurse” or “RN” - a person licensed as a registered nurse in accordance with applicable District laws and regulations. An RN is a qualified practitioner.

“Rehabilitation/Day Services” - a structured, clinical program intended to develop skills and foster social role integration through a range of social, psycho-educational, behavioral, and cognitive mental health interventions.

Rehabilitation/Day Services are curriculum-driven and psycho-educational and assist the consumer in the retention, or restoration of community living, socialization, and adaptive skills. Rehabilitation Day Services include cognitive-behavioral interventions and diagnostic, psychiatric, rehabilitative, psychosocial, counseling, and adjunctive treatment. Rehabilitation/Day Services are offered most often in group settings. Rehabilitation/Day Services is a specialty service.

“Service specific standards” - the certification standards described in §3414, §3415, §3416, §3417, §3418, §3419, §3420, §3421, §3422 and §3423, which set forth the specific requirements applicable to each MHRS.

“Specialty provider” - a community-based organization MHRS provider certified by DMH to provide specialty services either directly or through contract. Each specialty provider shall enter into an affiliation agreement with each DMH-certified CSA.

“Specialty services” - ACT, CBI, Crisis Intervention/Emergency, Intensive Day Treatment, and Rehabilitation.

“Subcontractor” - a licensed independent practitioner qualified to provide mental health services in the District. A subcontractor may provide one or more core service(s) under contract with a CSA. A subcontractor may also provide specialty service(s) under contract with a specialty provider.

“Subcontractor Agreement” - an agreement by and between an MHRS provider and a subcontractor that describes how they will work together to benefit consumers in the form approved by DMH.

“Subprovider” - a community-based organization certified by DMH to provide one or more core service(s) through an affiliation agreement with a CSA.

“Triaging” - prioritizing the level of crisis services required by a consumer, based upon the assessed needs of the consumer.

DISTRICT OF COLUMBIA
DEPARTMENT OF MOTOR VEHICLESNOTICE OF FINAL RULEMAKING

The Director of the Department of Motor Vehicles, pursuant to the authority set forth in Sections 109 and 401 of the Department of Motor Vehicles Reform Amendment Act of 2004, effective April 8, 2005 (D.C. Law 15-307); Section 1825 of the Department of Motor Vehicles Establishment Act of 1998, effective March 26, 1999 (D.C. Law 12-175; D.C. Official Code § 50-904); The Compulsory/No-Fault Motor Vehicle Insurance Act of 1982, effective September 18, 1982 (D.C. Law 4-155, D.C. Official Code § 50-1301.35 *et seq.*); The Traffic Adjudication Act of 1978, effective September 12, 1978 (D.C. Law 2-104; D.C. Official Code § 50-2301.01 *et seq.*); §§ 7 and 13 of the District of Columbia Traffic Act of 1925, effective March 3, 1925 (43 Stat. 1125; D.C. Official Code §§ 50-1401.01 & 50-1403.01); Regulation No. 72-13, effective June 30, 1972 (32 DCRR; 18 DCMR § 302); and Mayor's Order 03-58, effective April 21, 2003, hereby gives notice that final rulemaking action was taken to amend Chapters 1, 3, 4, 5, 8, 13, 22, 24 and 27 of Title 18 of the District of Columbia Municipal Regulations (DCMR) (Vehicles and Traffic). These rules define the types of motor vehicle safety equipment required for a vehicle used in a driver's test, deny a road test to any applicant that drives to the test site in violation of the learner's permit restrictions, conform the regulations to the law by permitting either a distinguishing number or social security number to be displayed on the driver's license, allow an applicant to complete a District of Columbia certified motorcycle demonstration course to obtain a motorcycle endorsement, link special identification card application requirements with driver's license application requirements, provide for the reinstatement of a license suspended or revoked for an alcohol or drug related offense if the person was approved for a diversion program by the Superior Court of the District of Columbia, require customers applying for a title certificate to pay all outstanding fines, fees, and penalties, establish acceptable sources for determining the fair market value of a motor vehicle for salvage vehicle reporting purposes, extend the duration of special use identification tags, clarify the regulation for refusing to issue or alter a certificate of title, require an owner whose vehicle has been immobilized for failure to display current registration or reciprocity sticker to present valid tags, valid temporary tags, or a valid reciprocity sticker to reclaim the vehicle, eliminate duplicative provisions in Chapter 8, clarify the type of proof of insurance that anyone convicted of certain enumerated offenses must supply, require all drivers converting a CDL with a hazardous materials endorsement from another state to pass a hazardous materials test, establish waiting periods to take a CDL skills exam after obtaining a CDL learner's permit or failing a previous exam, require an owner or operator whose vehicle has been impounded to either surrender any expired tags and tow the vehicle from the impoundment lot or present valid tags, temporary tags, or a reciprocity sticker to drive the vehicle from the impoundment lot, and match the duration of parking placards issued to persons with non-permanent physical disabilities to the likely duration of the physical disability, as determined by the Director. No public comments were received. A citation error was corrected, but no other changes have been made to the text of the proposed rules, as

published under the Notice of Proposed Rulemaking on May 6, 2005, at 52 DCR 4430. These final rules will be effective upon publication of this notice in the *D.C. Register*.

Title 18, DCMR, is amended as follows:

A. Chapter 1, ISSUANCE OF DRIVER'S LICENSES, is amended as follows:

- 1) Section 102, DRIVING UNDER INSTRUCTION: LEARNER'S PERMITS, subsection 102.4, paragraph (a) is amended by striking the phrase “, motorcycle,”.
- 2) Section 104, EXAMINATION OF APPLICANTS FOR DRIVER'S LICENSES, is amended as follows:

a) Subsection 104.4 is amended to read as follows:

104.4 No road test shall be given by the Department unless a device is easily accessible by the examiner seated in the passenger seat that enables the examiner to take control of the vehicle in an emergency. Such device may include, but is not limited to, a handbrake located between the driver seat and the passenger seat or a second steering wheel and/or brake located on the passenger side.

b) Subsection 104.12 is amended to read as follows:

104.12 No road test shall be given to an applicant who drives to the road test in violation of learner's permit restrictions in section 7 of the District of Columbia Traffic Act of 1925, approved March 13, 1925 (43 Stat. 1121; D.C. Official Code § 50-1401.01(a)). Any applicant who violates this section shall not be permitted to take the road test for six (6) months.

3) Section 107, LICENSES ISSUED TO DRIVERS, is amended as follows:

a) Subsection 107.2 is amended by striking the phrase “social security number” and inserting the phrase “distinguishing number or social security number, as provided by § 7(b)(1) of the District of Columbia Traffic Act of 1925, effective March 3, 1925 (43 Stat. 1125; D.C. Official Code § 50-1401.01 (b)(1))”.

b) Subsection 107.13 is amended by striking the phrase “ or Maryland” and inserting the phrase “, Maryland, or DC, if offered” in its place.

4) Section 112, SPECIAL IDENTIFICATION CARDS, subsection 112.2 is amended by adding to the end of the sentence the phrase “that includes the information required by § 103.2 of this chapter”.

- B. Chapter 3, CANCELLATION SUSPENSION OR REVOCATION OF LICENSES, section 306, PERIOD OF SUSPENSION OR REVOCATION, is amended by adding three new subsections 306.11 through 306.13 to read as follows:

- 306.11 Any person whose driving privileges were withdrawn pursuant to § 13 of the District of Columbia Traffic Act of 1925, effective March 3, 1925 (43 Stat. 1125; D.C. Official Code § 50-1403.01), and who was approved for a diversion program by the Superior Court of the District of Columbia, may apply to the Director for dismissal of the revocation or suspension action.
- 306.12 If a hearing was requested on the suspension or revocation, the request for dismissal pursuant to 306.11 must be made no fewer than five (5) days before the scheduled hearing date.
- 306.13 Any license reinstated because the action was dismissed pursuant to § 306.11 shall be conditioned on the successful completion of the diversion program.

- C. Chapter 4, MOTOR VEHICLE TITLE AND REGISTRATION, is amended as follows:

- 1) Section 401, APPLICATION FOR A CERTIFICATE OF TITLE, is amended as follows:
 - a) Subsection 401.16 is amended by striking the D.C. Official Code reference “§ 50-2201.02(j)” and inserting the D.C. Official Code reference “§ 50-2201.03(j)” in its place.
 - b) A new subsection 401.17 is added to read as follows:

401.17 An application for a title, other than a duplicate title, shall not be accepted unless all of the new owner’s outstanding fines, fees, and penalties imposed pursuant to the District of Columbia Traffic Adjudication Act of 1978, effective September 12, 1978 (D.C. Law 2-104; D.C. Official Code § 50-2301.01 *et seq.*) have been satisfied.
- 2) Section 404, NON-NEGOTIABLE CERTIFICATES OF TITLE, is retitled NON-NEGOTIABLE CERTIFICATES OF TITLE; SUPPLEMENTARY CERTIFICATES OF TITLE FOR LIENS and is amended by redesignating subsection 405.1 as subsection 404.4.
- 3) Section 405, SUPPLEMENTARY CERTIFICATES OF TITLE FOR LIENS, is retitled SALVAGE TITLE AND NON-REPAIRABLE VEHICLE CERTIFICATE and is amended by adding a new subsection 405.1 to read as follows:

- 405.1 For the purposes of determining whether a vehicle is a Salvage Vehicle under § 101 of the Department of Motor Vehicles Reform Amendment Act of 2004, effective April 8, 2005 (D.C. Law 15-307); the Director shall use the then current National Automobile Dealers Association (NADA) Guide for the Eastern Region; except that an insurance company may use any fair market value guide regularly used by the insurance company.
- 4) Section 406, DUPLICATE CERTIFICATES OF TITLES, is amended by adding a new subsection 406.8 to read as follows:
- 406.8 An application for a duplicate certificate of title shall be accepted regardless of the status of any outstanding fines, fees and penalties imposed pursuant to the District of Columbia Traffic Adjudication Act of 1978, effective September 12, 1978 (D.C. Law 2-104; D.C. Official Code § 50-2301.01 *et seq.*).
- 5) Section 410, REFUSAL TO ISSUE OR ALTER CERTIFICATES OF TITLE AND SUSPENSION OR REVOCATION OF CERTIFICATES OF TITLE, subsection 410.1 is amended to read as follows:
- 410.1 If the Director determines that an applicant for a certificate of title is not entitled to the certificate, or that a person who requests that a certificate be officially altered is not entitled to that alteration, the Director shall refuse to issue the certificate or make the alteration.
- 6) Section 416, TRANSFER OF REGISTRATION TO ANOTHER VEHICLE, subsection 416.5 is amended by striking the phrase "twenty (20)" and inserting the phrase "forty-five (45)" in its place.
- 7) Section 426, SPECIAL USE IDENTIFICATION TAGS, subsection 426.5 is amended by striking the phrase "twenty (20)" wherever it appears and inserting the phrase "forty-five (45)" in its place.
- 8) Section 431, IMMOBILIZATION OF MOTOR VEHICLES, subsection 431.1 is amended as follows:
- a) Paragraph (a) is amended by striking the word "and" at the end of the paragraph.
- b) Paragraph (b) is amended by striking the period at the end of the paragraph and adding the phrase "; and" in its place.
- c) A new paragraph (c) is added to read as follows:
- (c) The owner presents proof they were issued a valid:

- (1) Registration;
- (2) Special use identification tag; or
- (3) Reciprocity permit.

D. Chapter 5, MOTOR VEHICLE DEALERS, is amended as follows:

- 1) Section 505, TEMPORARY REGISTRATION FORMS, subsection 505.4 is amended by striking the phrase "twenty (20)" and inserting the phrase "forty-five (45)" in its place.
- 2) Section 506, SPECIAL USE IDENTIFICATION TAGS, is amended as follows:
 - a) Subsection 506.5, paragraph (a) is amended by striking the phrase "twenty (20)" and inserting the phrase "forty-five (45)" in its place.
 - b) Subsection 506.6 is amended by striking the phrase "twenty (20)" and inserting the phrase "forty-five (45)" in its place.

E. Chapter 8, SAFETY RESPONSIBILITY, is amended as follows:

- 1) Section 804, SUSPENSION OF REGISTRATION AND LICENSE: UNSATISFIED JUDGMENT, is amended by repealing subsections 804.1 through 804.9.
- 2) Section 805, PROOF OF FINANCIAL RESPONSIBILITY, subsection 805.2 is amended to read as follows:

805.2 For purposes of the Act, the requirement to submit proof of financial responsibility shall be satisfied by submission of a form customarily used by the insurance industry for that purpose including, but not limited to, the SR-22.

F. Chapter 13, CLASSIFICATION AND ISSUANCE OF COMMERCIAL DRIVER'S LICENSES, is amended as follows:

- 1) Section 1315, COMMERCIAL DRIVER'S LICENSE KNOWLEDGE TEST, subparagraph 1315.1 (e)(2) is amended by striking the phrase " if the applicant has not passed the test for endorsement within the two (2) years preceding the conversion".
- 2) Section 1316, COMMERCIAL DRIVER'S LICENSE SKILLS TEST, is amended by adding three new subsections 1316.3 through 1316.5 to read as follows:

- 1316.3 An applicant may not take the commercial driver's license skills test until at least thirty (30) days have elapsed from the issuance of a learner's permit.
- 1316.4 An applicant must wait the following periods after failing a commercial driver's license skills test:
- (a) At least sixty (60) days from the first unsuccessful attempt; and
 - (b) At least ninety (90) days from any subsequent unsuccessful attempt.
- 1316.5 An applicant may take the commercial driver's license skills test no more than three (3) times in a twelve (12) month period.
- 3) Section 1327, PHYSICAL QUALIFICATIONS AND EXAMINATIONS, subsection 1327.4 is amended by striking the phrase "(j)" at the end of the subsection.
- 4) Section 1328, PATRIOT ACT COMPLIANCE, is amended by adding the word "USA" to the beginning of the title.
- G. Chapter 22, MOVING VIOLATIONS, section 2224, ALCOHOLIC BEVERAGES IN MOTOR VEHICLES, is amended by moving the text in subsection 2224.4, which pertains to the definition of opened alcoholic beverage container, to a new subsection 2224.5.
- H. Chapter 24, STOPPING, STANDING, PARKING, AND OTHER NON-MOVING VIOLATIONS, Section 2421, IMPOUNDMENT OF VEHICLES FOR VIOLATIONS, is amended by adding a new subsection 2421.7 to read as follows:
- 2421.7 The owner or lien holder (or a person duly authorized by either) of an impounded vehicle with expired registration or reciprocity permit shall, in addition to satisfying the requirements in § 9 of the Removal and Disposition of Abandoned and other Unlawfully Parked Vehicles Reform Act of 2003, effective October 28, 2003 (D.C. Law 15-35, D.C. Official Code 50-2421.09 (2001)), either surrender their tags or reciprocity permit and tow the vehicle from the impoundment lot, or present proof of the issuance of valid registration, a valid special use identification tag, or a valid reciprocity permit.
- I. Chapter 27, SPECIAL PARKING PRIVILEGES FOR PHYSICALLY DISABLED PERSONS, section 2704, ISSUANCE OF SPECIAL LICENSE TAGS OR PARKING PERMIT, is amended by adding a new subsection 2704.9 to read as follows:
- 2704.9 Any permit issued to a person qualifying under § 2701.1(e) shall be issued for the likely duration of the disability, as determined by the Director.